THE CANADIAN HOSPITAL

OFFICIAL JOURNAL
CANADIAN HOSPITAL COUNCIL

SEPTEMBER, 1947

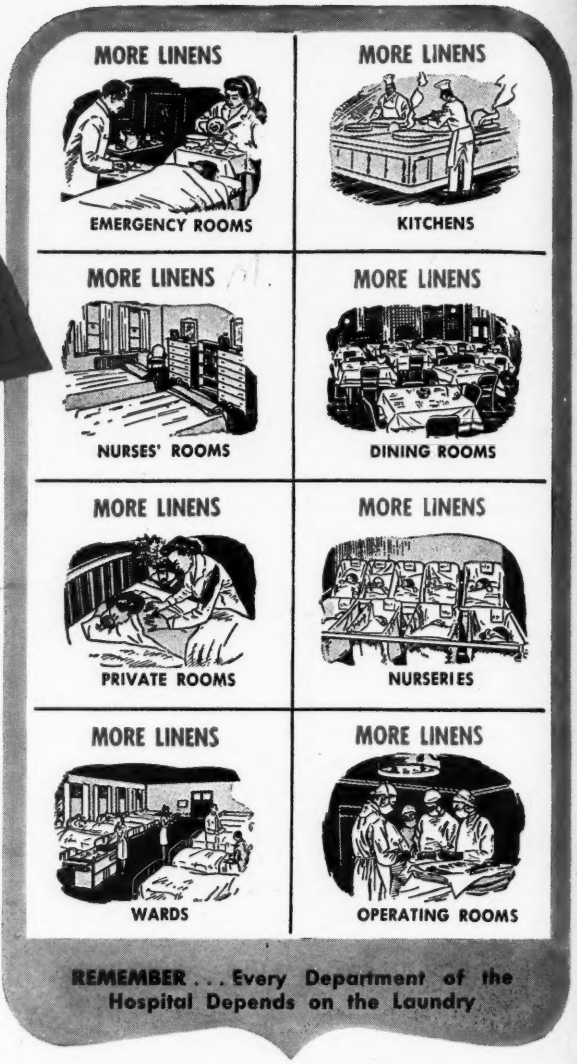
ARE YOU "STINGY" with CLEAN LINENS?

Been forced to ask your staff to economize on linens—even at expense of patients' comfort? The trouble is in the laundry, seriously overburdened by demands of increased occupancy.

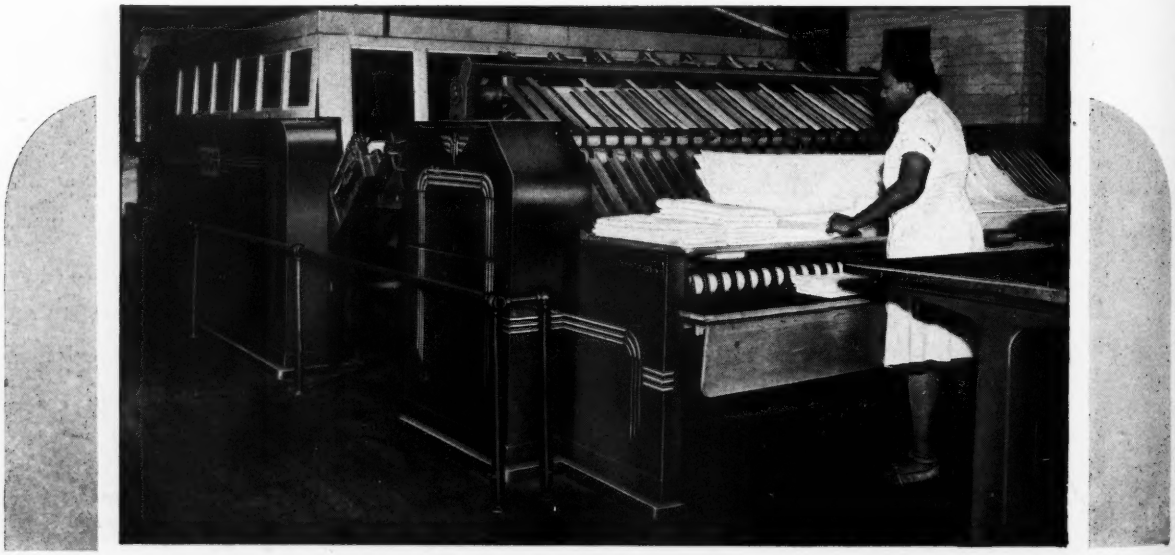
A *modernized* laundry will give you all the additional clean linens you need. Today's high-speed laundry machines turn out more work in less time. Quality of work is greatly improved. Faster laundering returns linens to service on shorter schedule. You need less linen inventory. Yet all departments have plenty of linens for emergencies. And you save money through reduced production costs.

Think it over. Every department must have a plentiful supply of clean linens to function properly. Ask for a free survey with recommendations by our Laundry Advisor. WRITE TODAY.

The
CANADIAN LAUNDRY MACHINERY CO. LIMITED
47-93 STERLING ROAD, TORONTO 3, ONT.



● *Installation of modern 8-Roll SYLON Flatwork Ironer with TRUMATIC Folder—irons linens beautifully at high speeds and folds large pieces automatically, with big labor-savings.*



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Pioneer name in parenteral therapy

● A Protein Hydrolysate Solution that is conspicuously reaction-free is another achievement of Baxter research. The perfecting of Protein Hydrolysate Baxter marks an important addition to Baxter's integrated parenteral therapy program . . . with its complete range of solutions . . . sets for separate or simultaneous infusions . . . its wide selection of simplified equipment for standardized procedures. No other method is used by so many hospitals.

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Contents

Vol. 24 **SEPTEMBER, 1947** No. 9

Canadian Hospital Council

The Federation of Hospital Associations in Canada in co-operation with the Federal and Provincial Governments and the Canadian Medical Association

EDITORIAL OFFICES: 280 BLOOR ST. WEST, TORONTO 5, ONT.

CCAB

BNA

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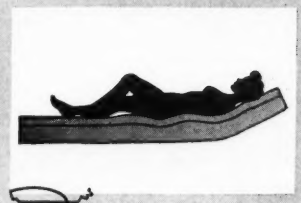
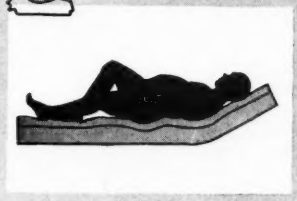
ONLY EXPERIENCE *Proves* DURABILITY!

"Controlled Comfort"



"Controlled Comfort," for every hospital patient, is assured with Spring-Air hospital mattresses! Spring-Air spring construction *automatically adjusts* to the weight of the patient . . . conforms to, and supports, the contours of the body — thereby aiding *every patient*, regardless of weight, in getting the best possible comfort and rest.



10—12—15, EVEN 18 YEARS OF CONTINUED HOSPITAL USE PROVE THE VALUE OF SPRING-AIR

THERE'S no "guess" or "promise" about this: the records PROVE that Spring-Air Mattresses give outstanding dollar-for-dollar value through year-after-year of tough, continuous hospital service . . . that they render the individual-patient-comfort which contributes to speedy patient recovery . . . and to hospital good-will.

MORE THAN TWO THOUSAND hospitals, large and small, are using Spring-Air Mattresses, thousands of which have already given comfortable service for 10-12-15, even 18 years of continuous use. (Names of long-term users supplied on request.) This combined experience of actual hospital performance — and Spring-Air construction know-how and engineering ability — *proves* Spring-Air value in durability, service and comfort.

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PARKHILL BEDDING LIMITED,
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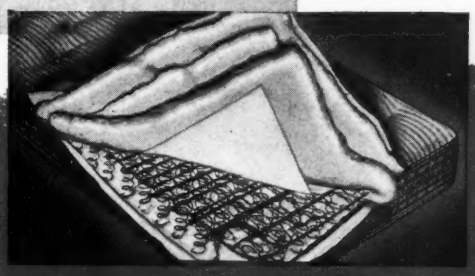
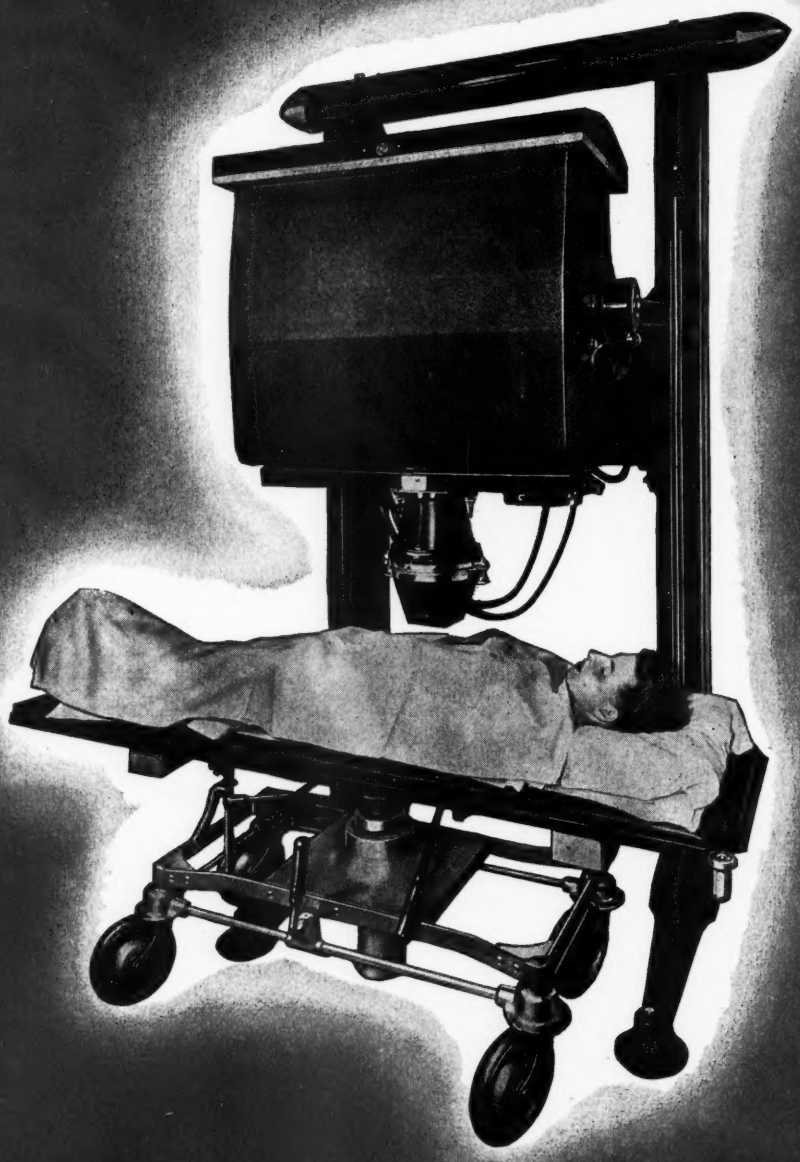
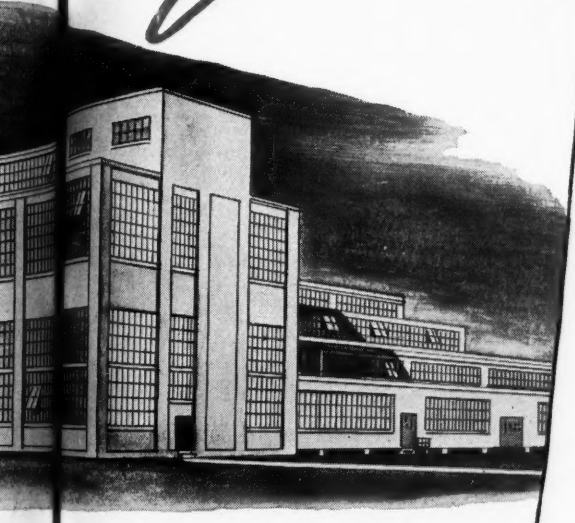


Spring Air MATTRESSES HOSPITAL

Although no expense is spared in extensive research and factory testing, Spring-Air does not rely on mechanical tests alone . . . The best evidence of Spring-Air quality, in every detail of design and construction, is the *satisfaction* of many years of use in over 2000 hospitals.

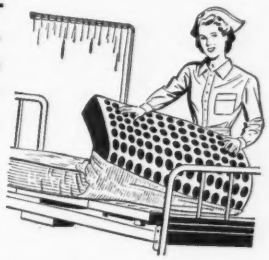


HUGE NEW PLANT Airfoam IN CANADA



NEW AIRFOAM HOSPITAL MATTRESS IS MIRACLE OF COMFORT... COOL... SANITARY . . . ECONOMICAL

The restful, therapeutic comfort that AIRFOAM provides for patients is only *one* of the reasons why hospital authorities specify and favor the new AIRFOAM hospital mattress. AIRFOAM is porous . . . cool . . . self-ventilating. It is dust and vermin-proof . . . resistant to germs. The AIRFOAM mattress has a smooth, uniform surface. It is resilient . . . needs no turning . . . lasts for years and years with original cushioning qualities.



All these advantages of AIRFOAM are available also in ring seats, wheel chair pads, operating table pads, ambulance mattresses, knee pads, etc.

Write direct to Goodyear for full information on the contribution AIRFOAM can make to improved hospitalization at lower long-term cost.

Address enquiries to Special Products Division, Goodyear, New Toronto, Ont.

SPECIFY Airfoam

A PRODUCT OF GOODYEAR

THE GREATEST NAME IN RUBBER

Airfoam—Registered Canadian Trade Mark

Across the Desk

By C. A. E.

Britain's Roffey Park Training Centre

BRITAIN'S first industrial rehabilitation centre, Roffey Park, has opened a new training and research department where medical officers, personnel managers, and social workers from Britain and other countries may go to study the medical and psychiatric problems of industrial workers. The students will have a particularly good opportunity to learn methods of salvaging industrial health, for more than a thousand cases of maladjusted workers are treated at Roffey Park yearly, and at all times the students will be brought closely in touch with the methods of treating them.

Roffey Park was established during the war under the auspices of the National Council for the Rehabilitation of Industrial Workers, with the full approval of the Government. A large country house on a wooded estate in Sussex, about thirty miles south of London, was purchased with funds given by 178 progressive industrial firms in Britain. It was equipped to give residential treatment concurrently to 120 patients with indeterminate ill-health arising from industrial fatigue, depression, nervous debility, and other occupational or psychological disorders. The object is to salvage these "medical casualties" of industry, and return as many as possible to full-time productive capacity. Those with deep-seated difficulties likely to need much more than six weeks of treatment are not accepted.

* * * *

New Magazine for Trustees

Publication of a pocket-size monthly magazine, "Trustee", for hospital governing boards will begin before October 1, the American Hospital Association has announced.

"Trustee" will be one part of the Association's program for hospital trustees and is a result of work of a special committee, headed by Ray E. Brown, superintendent of University of Chicago Clinics. A study of problems of hospital trusteeship as separate from those of hospital administration preceded production of a sample copy of the magazine which was approved by the Association's Board of Trustees in June.

Editorially, "Trustee" will be "educational, readable and strictly pertinent to the realm of trustee responsibilities," according to the Association announcement.

The magazine, which will contain no advertising, will be distributed among hospital administrators and trustees. Presidents of the boards of Association institutional members will receive a copy of the magazine automatically. Institutional member trustees and administrators will be invited to subscribe at a special rate of $2 a year, and other persons may subscribe for $3 a year.

(Continued on page 16)

Centralization means economy

Few hospital departments which form the chain of services that focus on the surgery, can offer an economy potential comparable to the

This increasingly important service can function to centralize equipment necessary for the preparation of surgical solutions, whole blood and plasma facilities. . . . FENWAL EQUIPMENT permits independent production control by the hospital.

The Fenwal technic of producing sterile fluids is appreciably less difficult than that of collecting blood and producing plasma. . . . FENWAL EQUIPMENT can be operated accurately and safely by any trained attendant.

Negligible space is required for a Fenwal installation, a major proportion of which is essential to the blood bank facility as well. Centralization can thus mean important economies in time and labor *plus* the savings in Solution costs that will many times exceed the outlay for equipment and supplies.

THE Stevens COMPANIES

Fenwal

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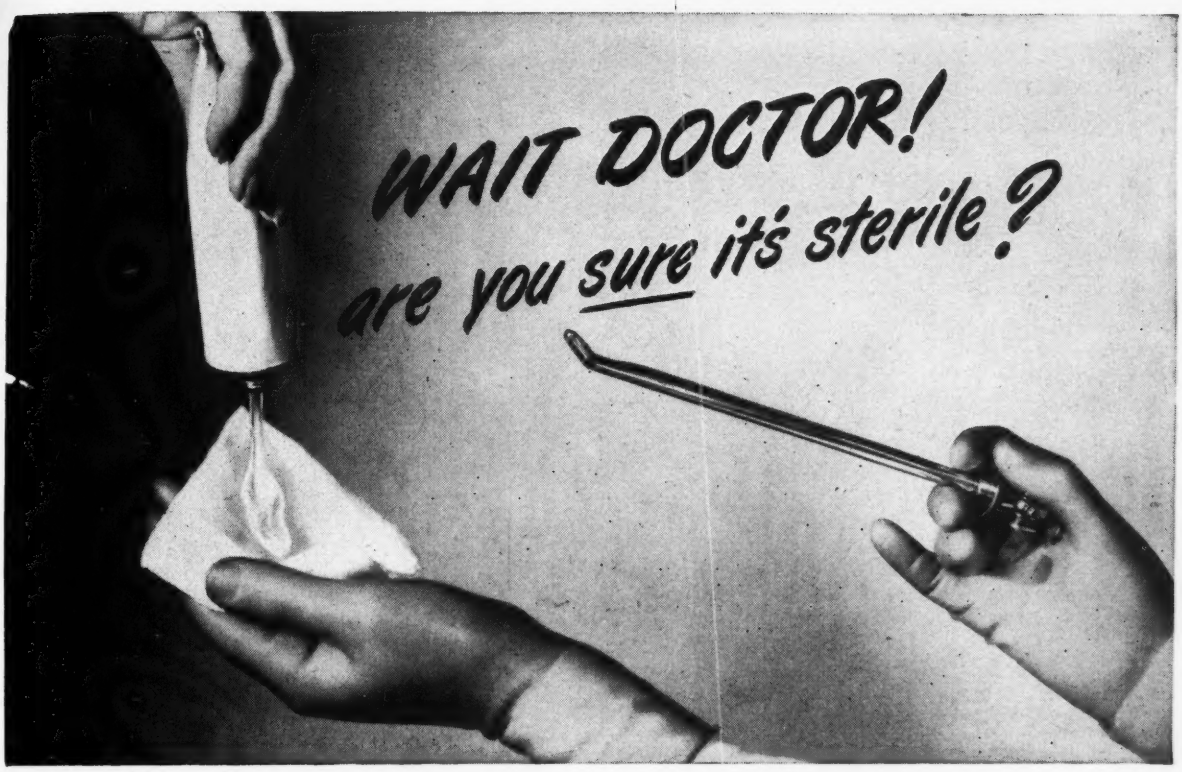


YOUR gowns, gloves, instruments and dressings are always sterilized . . . but this whole meticulous technique is broken unless your lubricating jelly, too is sterile.

Check the jelly you are using. If it's K-Y*, it is sterile . . . the tube is so marked . . . and every tube is pressure-sealed under the cap for extra protection.

You are sure when it's

K-Y

LUBRICATING JELLY

Active ingredients of K-Y: chondrus, tragacanth, glycerine, water and boric acid.

Johnson & Johnson
LIMITED MONTREAL

*Registered Trade Mark

Across the Desk

Two Curtis Bulletins

Curtis Lighting of Canada Limited has issued two new bulletins which are now available upon application.

The "Forty-Sixty" bulletin shows specifications as well as the different applications to which this luminaire is adapted in offices, hospitals, drafting rooms, school rooms and laboratories. High levels of illumination without distracting and harmful glare are readily attained with this unit.

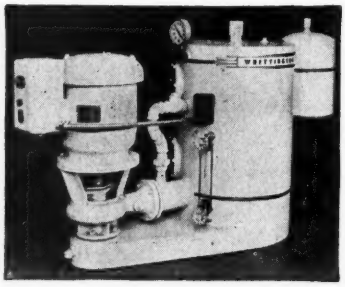
The other bulletin is the first to be devoted to the Tranquilouver—a new fluorescent luminaire with engineered louvers. The bulletin shows the approximate foot-candle values through the use of single two lamp unit, single three lamp unit and single four lamp unit. Much helpful data is given, including data on hangers for suspending Tranquilux units from the ceiling.

The bulletins are available upon application to Custis Lighting of Canada Limited, 195 Wickstead Avenue, Leaside, Toronto 12.

* * * *

Whittington Clinical Vacuum System

The Whittington Clinical Vacuum System introduces the water-jet vacuum process pump into the hospital field. The purpose is the withdrawal of blood and pus from patients during surgical operations. This unit differs from the conventional vacuum pump in that there are no close clearances to wear and call for adjustment, and eventually replacement. Water, recirculated through a tank and jets by a centrifugal pump, sets up a suction of air which creates the vacuum. Twenty years of trouble-free service may be expected from this unit, it is claimed.



Should any of the interceptor jars in the operating rooms overflow there is no need for alarm. This unit in the basement or boiler room comprises an auxiliary stainless steel interceptor tank which may be quickly flushed out daily by a maintenance man.

A vacuum volume chamber is an integral part of the pump. A vacuum switch automatically maintains in this volume chamber any desired vacuum up to and including 28″ (hg). Ordinarily 15″ to 25″ vacuum is desired for this purpose.

The sizing of the unit is not difficult. Merely state the total number of operating tables or vacuum connections in the operating rooms. This unusual unit is a product of an Indianapolis, Indiana, manufacturer, the Whittington Pump & Engineering Corporation, which specializes in sub-atmospheric equipment. The Canadian representative is Mr. J. A. Christie, 670 Dundas Street West, Toronto. Additional information will be gladly furnished.

(Concluded on page 20)

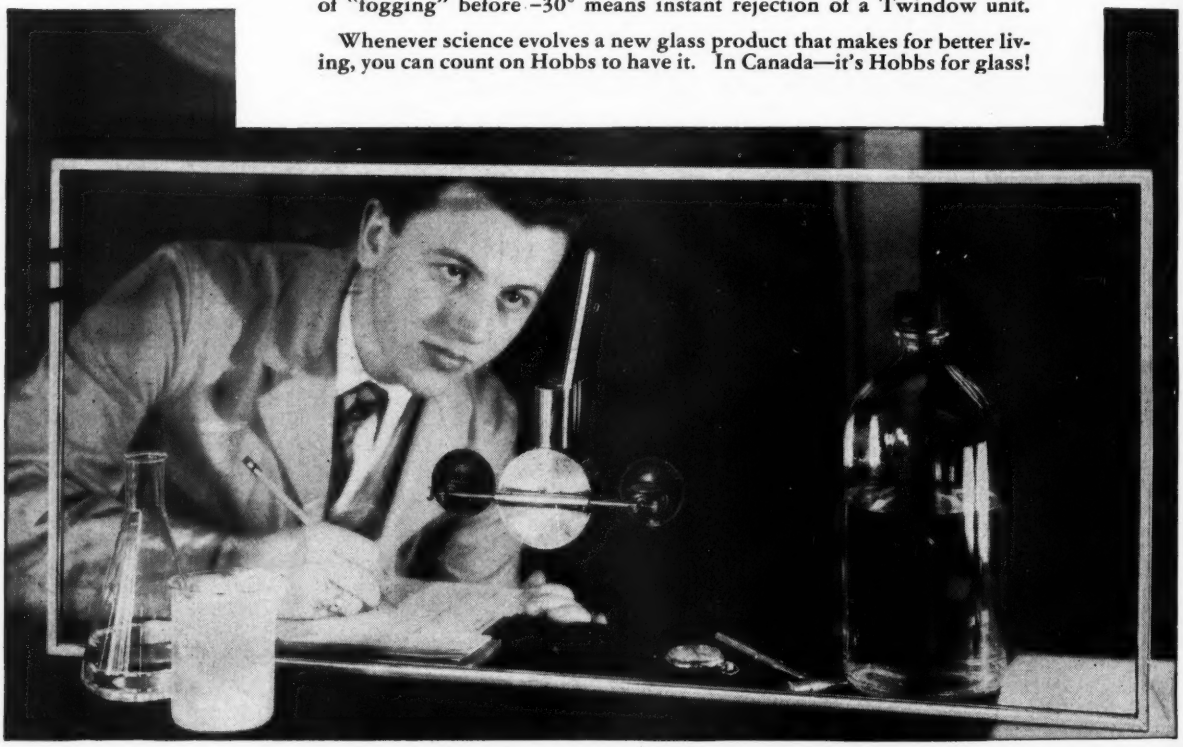
This window won't weep in winter!

At last, modern glass research has developed a window that actually *insulates* . . . virtually prevents fogging up and "weeping." It's done by sealing dry, dead air between two panes of glass. It's TWINDOW . . . the newest development in double glazing.

Twindow is a *permanent* insulating unit . . . the result of years of intensive research . . . with a scientifically designed seal and stainless steel frame. Twindow's hermetic seal *stays* sealed! Its proved efficiency is typical of all glass products sold by Hobbs. Made in Canada!

Every Twindow unit is subjected to the rigorous "dew-point" test. Temperature of sealed air is chemically lowered to −75°. Any evidence of "fogging" before −30° means instant rejection of a Twindow unit.

Whenever science evolves a new glass product that makes for better living, you can count on Hobbs to have it. In Canada—it's Hobbs for glass!



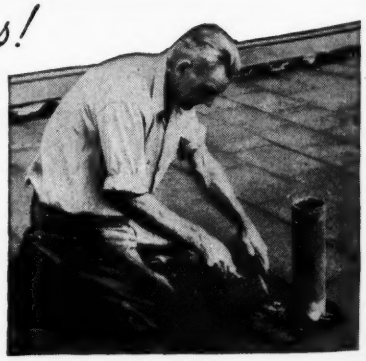
• *Dry ice and acetone in brass container lower temperature during the dramatic "dew-point" test.*

Now insulate permanently with Foamglas!

Here at last is a permanent insulation, made of glass and air! Rigid and strong, Foamglas will not swell, shrink, powder or rot. It is waterproof, verminproof, fireproof . . . withstands the attack of most acid fumes. It will not slip, slide or pack down. Yet it is so light that it floats!

On roofs, in walls and floors, Foamglas helps control temperature . . . eliminates maintenance. With Foamglas, first cost is last cost! For descriptive folder write to Hobbs Glass Limited, Dept 15, London, Canada, or call our local branch—there's one near you!

Come to Hobbs too for: Twindow insulating windowpanes • PC Glass Blocks • Corrugated glass • Coolite glare-reducing glass • Herculite tempered glass • Nucite glass chalkboard • Plate glass • Safety glass • Mirrors • Carrara • Plexiglas



Look to GLASS for better living- HOBBS GLASS LIMITED *come to HOBBS for glass!*

"That LINOLEUM floor was a real investment!"

IT'S over a period of years that one appreciates the true worth of a linoleum floor. It is the economical answer to the question, "How much of your overhead is underfoot?"

No other floor is so durable, or so economical in the way of maintenance cost. And no floor is so *resilient.* Sound deadening Linoleum is always springy—easy to walk on. A damp mop cleans it, an occasional waxing and polishing keeps it always bright and new.

Wherever the traffic is heavy and constant —durable, resilient linoleum is the floor.

75 Years of Progress

This year Dominion Oilcloth & Linoleum Company, Limited celebrate their 75th Anniversary. From a very small beginning in 1872 this company has grown to become one of the most important industrial concerns in Canada. Its products, famous for their quality, are known from coast to coast.

LINOLEUM *Is Still Scarce . . .*

but planning ahead is always advisable. Ask your architect, linoleum contractor or dealer NOW for suggestions on your particular floor needs.

DOMINION OILCLOTH & LINOLEUM
Company, Limited - - - Montreal

DOMINION
BATTLESHIP LINOLEUM
and
MARBOLEUM

Across the Desk

Cooling Oxygen Masks

During hot, humid days an oxygen face mask is apt to become uncomfortable even though it is removed frequently for sponging and drying of the patient's face. It has been suggested that immersion of the tubing leading from the regular outlet to the mask in ice water gives a cooling effect. Additional cooling can be gained if several coils of the tubing are kept in ice water, but care should be taken to avoid kinking the tubing. Do not add additional lengths of tubing to the meter mask. Doing so will change the percentage concentrations of oxygen delivered to the breathing bag.

—Oxygen Therapy Bulletin of Dominion Oxygen Co. Ltd.

* * * *

New Synthetic Sweetener

A new synthetic sweetener — Sweet-aids — is now avialable. Sweet-aids tablets have no after-taste, dissolve speedily and completely and provide the sweetness equivalent to two teaspoonfuls of sugar per tablet, without the undesirable caloric content of sugar. Here is the clean fresh sweetness and taste of sugar without calories! Sweet-aids have no food value.

Wherever sugar is contra-indicated, Sweet-aids can be used in preference to Saccharin, it is claimed. Each Sweet-aid tablet is equivalent to two teaspoonfuls of sugar in sweetening power or ½ grain Saccharin tablet. Sweet-aids can be used in preference to Saccharin in diabetic diets.

Sweet-aids are distributed by Strathmore Products Company, 11-15 West Palisade Avenue, Englewood, N.J.

* * * *

G.E. Engineers Develop "Electronic Oven"

General Electric engineers in Syracuse, N.Y., have developed an "electronic oven" for use in establishments where it is desired to serve hot pre-cooked frozen meals quickly and efficiently. The unit heats these meals in about 75 seconds to an average temperature of 160° F.

The "electronic oven" is being operated in tests at Maxson Food Systems, of New York City. Until field tests have been completed, it is not planned to produce the equipment in large quantities, G.E. officials explained.

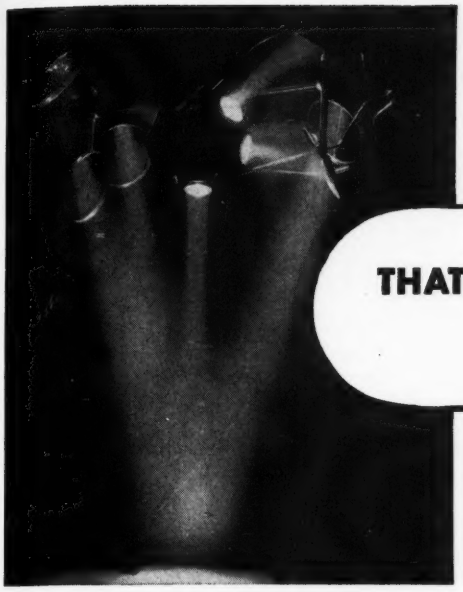
Application of the unit as presently designed would be limited to heating pre-cooked frozen foods and would not extend to general cooking as by conventional methods. It *is not* a home unit, G.E. emphasizes.

* * * *

Fluorescent Laundry Marking

The use of fluorescent paint to mark laundry is becoming increasingly common in Britain, reports Canadian Paint and Varnish Magazine.

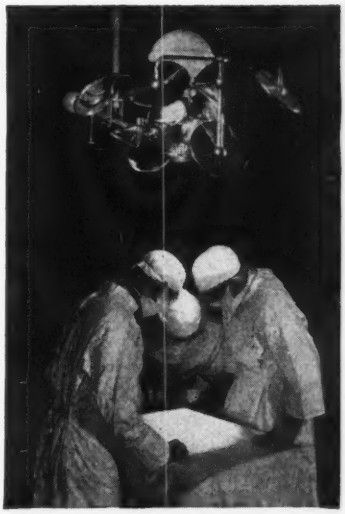
Many modern British laundries are eliminating the older systems of marking by threads or indelible pencil and are using invisible fluorescent paint which shines under ultra-violet light. When textiles have been washed and ironed, they are passed under an ultra-violet lamp which causes the fluorescent pigment to glow and enables the sorters to do their work.



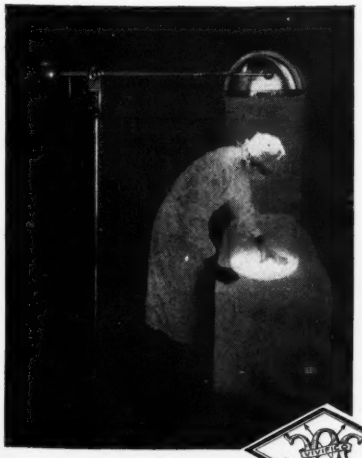
SURGICAL LIGHTING

THAT CONSERVES THE SURGEON'S ENERGY AND PREVENTS EYESTRAIN

Soft, White, Glareless Illumination At Any Angle



• The Operay Multibeam projects a powerful compound beam of light to the operating field from many directions—penetrates to the depth of the surgical cavity, despite hands, heads and shoulders of the surgeon and assistants over the operating field. The light rays from a 250-watt projection lamp are reflected from the internal mirrors within the projector, through six condensing lenses to corresponding external mirrors, and thence downward to the operating field. Completely adjustable within the area of an 84-inch circle over and around the operating table. (Made also in explosion-proof models, for use where explosive anesthetic gases are used.)



• Surg-O-Ray lighting fixtures provide excellent flexibility and intensity of illumination for operating room and delivery room use—may be raised, lowered, tipped or tilted and turned at any desired angle. Standard Surg-O-Ray fixture is equipped with twin-filament projection lamp. Each filament burns separately, or both filaments burn simultaneously when double intensity is desired. Made in portable stand and ceiling-hung models. Emergency model (battery equipped) has double-filament lamp—one filament operates on regular house current; second filament is connected to the fixture battery and operates from the battery current when regular current fails. When desired, ceiling Surg-O-Ray fixtures can be equipped with auxiliary ceiling lights for general room illumination.

Write for catalog on surgical lighting.

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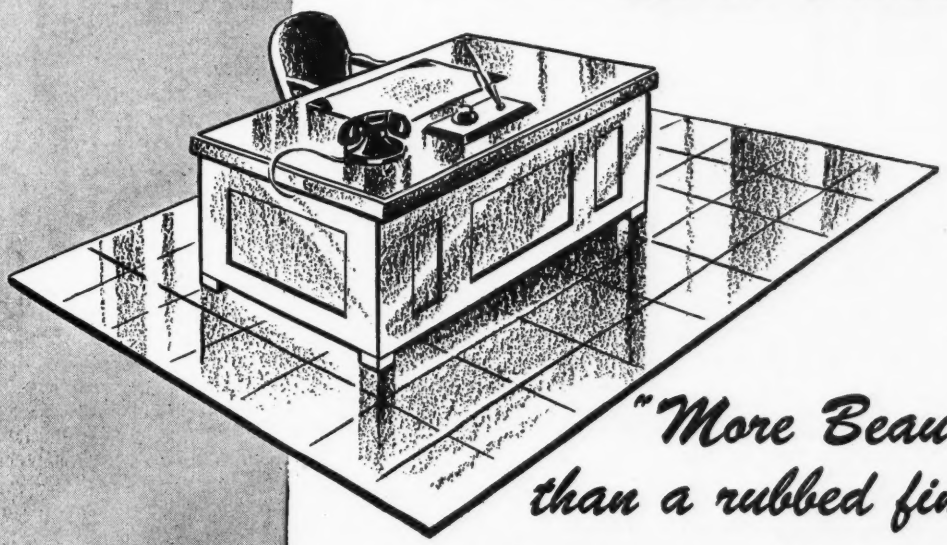
. . . THE NEW SATIN GLOSS



"More Beautiful than a rubbed finish"

Here's a durable, waterproof, beautifully-glossy finish for your Floors, Furniture, and Woodwork. D-B LACOL will not chip, crack or peel — retains shining surface under the heaviest wear and tear. Especially suitable for Schools, Hotels and Hospitals, D-B LACOL gives a greater coverage per gallon than varnish . . . an equally hard finish . . . and costs approximately half the price! Write today for a complete story of LACOL'S many uses.

Drums Half-Drums ¼-drums 5-Gal. Can 1-Gal Can

WEARS LIKE A STONE D-B 372

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Photograph of surgeon's scrub-up room

Duraclay *

As Good as the Day It Was Installed

To look at these scrub-up sinks of Duraclay you would think they were installed yesterday—but, as a matter of fact, they have been rendering service twenty-four hours a day ever since the hospital was built.

Duraclay was specifically developed by Crane ceramists for hospital service. Here are the reasons why you will find fixtures of Duraclay in such a large percentage of the nation's leading institutions:

- ★ It is highly resistant to thermal shock—sudden changes in temperature do not crack or craze its gleaming surface.
- ★ It will withstand abrasion, is not affected by strong acids and is not subject to staining.
- ★ It remains bright and sparkling even after years of service, and its hard glazed surface resists soiling — a damp cloth leaves it shining.

* ***Duraclay*** exceeds the rigid tests imposed on earthenware (vitreous glaze) established in Simplified Practice Recommendation R106-41 of the National Bureau of Standards.

THROUGHOUT THE HOSPITAL

— in surgery, examination department or scrub-up room, in hydrotherapeutic department, laboratory or washroom — wherever plumbing can aid in sanitation or in treatment — Crane has equipment for each particular job. Surgeons and hospital administrators have cooperated with Crane engineers in its design. Its quality construction assures long life and trouble-free service.

Consult your Plumbing Contractor or call your nearest Crane Branch for information.

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Harvey Agnew, M.D., Editor

The CANADIAN HOSPITAL

Toronto, September, 1947 Vol. 24 No. 9

HOPEFUL ASPECTS in the Fight *Against* CANCER

G. E. Richards,
M.D., F.R.C.P. (C), LL.D.
Radiologist, Toronto General Hospital.

SLOWLY but surely the tide, which from time immemorial has been running against us, is turning, and there is now more ground for optimism than at any previous time in the battle against Cancer — this most menacing and relentless of the diseases which afflict mankind. From the earliest days man's greatest handicap has been due to ignorance and superstition. But before we condemn our early predecessors in this matter we should make very sure that our own record is clear. The known facts about disease and the means which are necessary for its control now in the possession of the medical profession are such that, if they were put into effect, the incidence of sickness, loss of time and loss of life could be reduced as much as fifty per cent in one generation.

Numerous writers and speakers have stated that even if no great and spectacular specific cure were to be discovered, very important progress could be made by putting into effect the knowledge we already possess of the ways and means of combatting this disease, and that this is therefore *one of the hopeful aspects.* Moreover, very substantial progress has been made in recent years in connection with research into the fundamental nature of cancer and its possible cause or causes. But in the very forefront of the hopeful aspects of the fight we must place the fact that, almost for the first time, the measures which are being projected are of such a character as to justify the expression "War against Cancer".

Everyone knows that this disease occupies second place in the list of causes of death in all civilized countries, is responsible in our community for one hundred and thirty out of every thousand deaths, and that there are probably twenty thousand cases in existence in Ontario at all times. In six years of actual war our fighting forces suffered fatal casualties to the number of 41,992, but during the same period of time the toll taken by cancer in Canada amounted to 80,000. The cost to this country of six years of actual war was close to $19,000,000,000, while in the same period we spent on our efforts to combat cancer the comparatively paltry sum of less than $5,000,000. It is a mere platitude to say that had we carried on our fight in the actual war in the same haphazard and ineffectual manner as we have done and continue to do in the fight against cancer, we should most certainly have lost that war. We should face the sobering fact that up to the present *we have been losing* in our fight against cancer. Year by year the mortality tables which record the facts show the curve steadily and inexorably rising. And yet, reports from all treatment centres are to the effect that a higher percentage of cases are being cured than ever before — giving ground for the belief that we might expect a real war to be followed by a much greater measure of success than was ever previously possible. But to achieve such an end, the war must be real in the full modern meaning of that word; a war in which all who can make any possible contribution will unite for a combined, sustained and

From an address delivered at a special convocation of Queen's University, Kingston, Ontario, at which time the honorary degree of Doctor of Laws was conferred upon the author on the occasion of the opening of the Cancer Clinic at Kingston General Hospital, sponsored by the Ontario Cancer Treatment and Research Foundation.

In this massive radio-therapy unit are harnessed 400,000 volts of electricity. It is used for the treatment of cancer at the Toronto General Hospital.

co-ordinated effort towards a single aim. It means a complete mobilization of all the means at our disposal — both human and financial.

Realistic Facts

There is a popular word which has a place here. It is the word "realistic". There are certain facts in connection with cancer which must be faced in a very "realistic" way if we are not to let ourselves be deluded into an entirely false mental attitude. The "realistic" facts about cancer are that as a social problem it differs radically from many of the other important health problems, such as typhoid fever, tuberculosis, even infantile paralysis. These, especially the two former, can be combatted on a mass scale by controlling water, milk and food supplies at the source; by enforcing sanitary regulations which apply to and benefit entire communities; and by isolating those who carry the disease. In the case of tuberculosis the problem of "finding" the cases is at least capable of solution by the simple expedient of x-ray examinations of the entire population, making possible the segregation by authority of legislation of those found to be carriers of the disease. Cancer, on the other hand, is essentially a personal problem and, unless some new and radically different facts are found than anything at present known, is likely always to remain so. There is no simple test known, comparable to mass x-ray surveys, which can be applied to entire communities, and by which the presence of cancer can be recognized in the early stage. Its recognition depends upon personal observation, by the individual patient, of symptoms which frequently seem to him to be trifling and of no consequence; and, worst of all, these warnings are not painful.

Then, too, since it is not contagious or transmissible, the disease does not constitute a risk to others and therefore there can be no compulsion in the matter of treatment. Each patient must make his or her own decision as to what treatment will be accepted and when it will be undertaken.

Finally, a realistic attitude towards the subject must not overlook the fact that the discovery of the cause or causes of cancer might not lead directly nor immediately to the discovery of a specific cure. It did not do so in the case of tuberculosis and need not do so in cancer.

Cell Changes

In the leading article in the last Annual Report of the Ontario Cancer Foundation, Dr. Arthur Ham indicated that for many years it had appeared that the change which occurs when an otherwise normal cell becomes malignant, was best explained on the basis of cell mutation, to change which, as the writer pointed out, seemed like trying to interfere with destiny itself. Most of us have been more or less familiar with the general facts about cell mutation in nature and have been aware that under normal conditions such mutations occur spontaneously at long and unpredictable intervals. As a result of such mutations, new varieties or even new species of plants and animals are produced. It is now known that many factors are capable of speeding up or even initiating the process. In plants the drug colchicine is one, while in animals many coal-tar derivatives have the power of bringing about changes in the cell causing it to take on the characteristics which we define as malignant. These are the carcinogenic substances.

With the introduction of x-rays and radium, it became known that these radiations acted in the same manner and our knowledge of the problem was thereby advanced one step farther. Here was an effect upon the cell brought about not by an ordinaary chemical reaction, not by "irritation" in the chemical sense but by a non-material influence. In 1927 Müller began a series of experiments, using fertilized eggs of the fruit fly (Drosophila melanogaster) as his material. As the result of the valuable information gained from these experiments he was awarded the Nobel prize last year. Into this vast field the introduction of the electron microscope has added the precision required for accurate study, while the recent availability of extremely high voltage radiations, neutrons and products of atomic fission, has added new factors which have possibilities not only fantastic but *actually frightening.*

It is now assumed,* though not proven absolutely, that all spontaneous mutations are the result of ionization due to cosmic rays. To bring about such a mutation what is required is a direct hit by such radiations upon the chromosomes of the cell, of sufficient intensity to bring about an alteration in the composition of the hereditary gene. Such an alteration may produce a cell mutation immediately or not for several generations. But other radiations, including x-rays, gamma rays, neutrons and fission products, are capable of producing these changes at a greatly accelerated rate. For example, a dose of 3,000 r of Roentgen rays produces a mutation rate of 12 per cent, which is about one hundred times that occurring normally in nature. But in

Illustrations courtesy Canadian Cancer Society.

**Quoted in part from Leucutia, T.; American Journal of Roentgenology, Vol. 56, No. 3, September, 1946, pages 385-388.*

The electron microscope may play an important part in Canada's war against cancer.

Lead lined cabinet for radium applications. The nurse is protected by the lead.

the case of the alpha particle this rate is multiplied by something of the order of 3,700, while neutrons of boron or lithium increase it by 9,000 times, and the atomic particles of uranium fission by 130,000 times. Thus, we are provided with the means to bring about mutations for the purpose of experimental study on a scale never before possible. At the same time we are confronted with the means of our own destruction in a most horrible manner, since it has been pointed out by several writers that, if a sufficient concentration of such radiations were present in the atmosphere, cell mutations in the human race might be brought about, the ultimate results of which had best be left to the imagination.

From the standpoint of cancer research it is sufficient at the moment to consider that the alteration in the cell which results in a mutation is due to an alteration in an individual "gene" — usually resulting in a reduction in the number of genes in each chromosome. The result is entirely unpredictable, and the product may be a marvellously improved specimen and a thing of beauty, or it may be inferior, deformed or pathological.

Viruses

These facts take on new significance when considered in the light of recent developments in the study of viruses. From time to time the theory has been advanced that the cause of cancer might be a virus and, as is well known, this has been verified in at least one form of neoplasm, though not as yet in the human species.

Following the invention of the electron microscope with its very high-power magnification, a new concept of the nature of viruses has come about, which promises the possibility of an entirely new approach to the problem. This more modern concept regards a virus as essentially a "free gene", just as electricity may be defined as "free electrons". The result would be startling in the infinity of the combinations which could occur. Instead of speaking of viruses in general terms we would define them precisely. And just as there is a great variation in the pathogenicity of germs and the conditions under which they are or are not pathogenic, so there would be many variations of the conditions under which free genes will operate and the results which will occur under such conditions.

A closely related question constantly being asked since the discovery of atomic fission is: "Will not this discovery lead to a solution of the problem?" Some statements have been made which seem to those familiar with the subject to be very rash and exaggerated. Here again the "realistic" fact is that, while the discovery of atomic fission has placed in our hands much more powerful sources of radiation, these substances are still radiations and, therefore, no new *principle* has been introduced. The laws which govern the application of radiations to the human body are fundamentally two in number, and nothing which has so far been discovered has modified these laws in any particular. The first is that whether any neoplasm can be successfully influenced by radiations without undue injury to other tissues depends upon the degree to which it is capable of responding to such radiations, and the margin which exists between the dose required for its destruction and that which would destroy the normal tissues in which it is developing.

The second law is that which defines the amount and quality of radiation the blood-forming mechanism of the body can tolerate without irreparable damage.

Of these two the latter is probably the more important. Increasing the intensity and power of the radiations *might* conceivably result in an im-

(Continued on page 68)

We Look at Nursing Service

Sister Catherine Gerard, Reg. N.,
Director of Nursing, Halifax Infirmary.

"A HOSPITAL is a Sanctuary consecrated to the healing of the sick, and dedicated to the training of men and women in the art of medicine. Its staff should have a keen sympathy and a genuine love for the work, and for the human souls who occupy the sick beds." We limit our discussion here to the part played by the Nursing Service Department.

Organization of the Nursing Service

In order that each department may operate with the maximum of efficiency and maintain a consistently satisfactory standard of work, proper lines of authority must be established. The type of organization may differ in various hospitals, but the underlying principles remain the same, namely, to centralize authority, to fix responsibility, and to define duties and interrelationships. In *line* or *military* organizations, all major decisions or directions are made at the top and handed down to subordinates who break up the orders and execute them. In *functional* organization, each person is responsible to several heads, each of whom has something to control in his work, for example, clinical supervisors, or head nurses. *Line* and *staff* organization preserves full centralized administrative control, and offers the services of experts in an advisory capacity.

A brief survey of the internal organization within the hospital will indicate upon whom and what departments the main responsibility devolves for nursing service. At the top is the *board of governors,* responsible for seeing that the hospital functions are carried out economically and skilfully. Next is the *chief executive* or *administrator,* responsible to the governing body for the maintenance of the institution as a whole, and for the general welfare of the patients. Following on down the line are those directly concerned with the professional care of the patients, such as the *medical staff,* the *superintendent of nurses* with her assistants and instructors, and finally the *personnel* of the dietary, admitting and recording departments.

Upon the superintendent of nurses falls the bulk of responsibility, for she is the link between the medical and other allied health services. Her's is the dual obligation of providing adequate nursing care for the patients and, where the hospital conducts a school of nursing, suitable education for the student nurses. In no other period in the history of nursing have the cares of the superintendent of nurses loomed to such proportions because of the social, political and economic factors which are bringing such pressure to bear on our hospitals and personnel. It follows, therefore, that a thorough understanding of these situations and ability to cope with them are essential in order to elicit the maximum of service, with a minimum of expense and energy waste.

The newer emphasis on the education of the student nurse has shortened the number of hours she is actually engaged in bedside nursing daily and, therefore, makes it necessary to engage more graduate nurses to fulfil those duties which *cannot* and *should not* be delegated to the nurses' aide. Then, during the hours that the student is on duty, she must be more closely observed and directed so that the correlating of classroom instruction with ward teaching may be made practical. The fact that many of our students come directly from high school to hospital ward, and do not possess maturity of judgment with regard to the care of the sick, compels the superintendent to be moderately circumspect in her selection of head nurses and clinical supervisors; and again, the limited number qualified for either of these positions has tended to bring into the field of nursing education many who lack, in part at least, the personal and professional qualifications accepted as ideal. Moreover, numerous inventions and scientific discoveries, the products of recent wartime research, demand special training and the modification of one-time ironclad nursing procedures. These more scientific procedures should be left to the nurse, while other nursing tasks, such as baths, temperatures, carrying trays, et cetera, are gradually being handed over to subsidiary workers. The hospital management and the nursing profession must be flexible enough to adjust their methods in accordance with current trends while still maintaining a high standard of efficiency.[1]

The *quality* and *quantity* of nursing service have been decreased because of the demand for nurses in government services and in those hospital departments which formerly did not require nurses, for example, the x-ray department and laboratories. Meanwhile the *demand* for nursing has in no way diminished. On the contrary, it has increased a hundredfold. Group hospitalization plans are bringing more patients to our hospitals, and the layman, educated to an awareness of the facilities available for meeting his needs in the hospital, is insisting on receiving the nursing service he requires.

An economic factor which can not be overlooked when evaluating a nursing service, is the reiterated cry of staff duty nurses for shorter hours and higher wages. No one denies the fact that workers in cleri-

An address presented at the Maritimes Institute on Hospital Administration, June, 1947.

1. American Journal of Nursing, Sept., 1942, "Trends in Hospital Nursing Service", by J. A. Hamilton.

Can You Match This Bevy of Beauty?

There are bright moments even in the responsible, busy life of a lieutenant-governor! Note the pleased expression on the face of the Honourable Ray Lawson, Lieutenant Governor of Ontario, as he congratulates Student Nurse Avis Warrener, who welcomed him on behalf of the Sisters, the medical and nursing staffs of St. Joseph's Hospital, on a recent visit to London (Ontario), hospitals. Certainly these pretty student nurses make a particularly winsome picture and one that we believe will be hard to beat, anywhere!

cal, and even domestic occupations, receive a proportionately higher salary than the nurse, considering the length of time spent in preparation and the hours which constitute her day. My purpose in mentioning this, is not to suggest a remedy, but merely to point out that such a situation does exist, and does influence the number of graduates who will or will not work as staff nurses. From the hospital administrator's point of view the decrease in the quality of service is a genuine problem, since approximately 21 per cent of each hospital dollar goes into nursing service and nursing education.[2]

Effectiveness of Nursing Service

It is on the ward that all the resources of the hospital are brought to a focus. Unless there is wholehearted co-operation with all other departments, the nursing service cannot function as it ought. In his book, *Hospital Organization and Management,* Dr. MacEachern makes this statement: "The Nursing Service, constituting as it does approximately half the total personnel of the hospital, contacts all other departments, and while its duty is primarily the care of patients, it must co-operate with other departments if a smoothly working, harmonious and efficient organization of the whole is to be built up and maintained."[3] If this co-operation is lacking in some of our hospitals, we may seek the cause in one of two things: either the policies and regulations relating to each department have not been clearly defined and put down in writing or, if they have been defined, have not been sufficiently explained to those who must carry them out. With personnel changes occurring with such rapidity, we cannot afford to let well-ordered departments fall in the scale of efficiency by allowing new heads of these departments to make changes to suit their private notions.

On the ward, it is the head nurse, working under the direction of the superintendent of nurses, who makes the contacts with other departments, and her efforts to uphold and carry out their regulations will promote better service. It may be well here to clarify the term "head nurse". The *Manual of the Essentials of a Good Nursing Service* defines the head nurse as one who is responsible for the direct management and supervision of a single unit. The supervisor is defined as one who is responsible for developing and supervising one of the nursing services, such as medicine, surgery and obstetrics, or one who assists in supervising the department during the night. In some of our smaller hospitals, or those of non-segregated services, we

2. "Hospitals", 1940.

3. "Hospital Organization and Management", by M. T. MacEachern, M.D., Chapter IX.

do not use the term "head nurse", but we give the title of supervisor to the one in charge of the single unit. Whatever her title, it is *she* who establishes proper working relationships with other departments. She assists the business department, by seeing that charges to patients are promptly reported, and by notifying the office when a patient is about to leave the hospital, so that the necessary adjustments in the bill and arrangements for collection may be made in due time. She aids the admitting department by giving accurate information as to empty beds, so that the admitting staff may be able to judge how soon the beds will be available. The advantage of this is obvious.

In the accessory diagnostic and therapeutic departments, such as the operating room and x-ray department, the head nurse makes the work much lighter by having the patients properly prepared and in readiness at the appointed time.

In like manner, effective dietary service is dependent upon the fullest co-operation of the nursing service and, in particular, of the head nurse. Whatever the type of dietary service in the hospital, prompt and complete requisitions, based upon her knowledge of her patients' needs, are of prime importance if these needs are to be served. In hospitals where indirect service is the system, too much stress cannot be laid upon the need for supervision by the head nurse of all meals sent from the floor servery. Not less important to the patients' well-being, is the responsibility of the head nurse to arrange that they be in readiness for meals at the hour when trays are to be served.

Another department requiring the co-operation of the nursing service is the *record room.* It may sometimes be a temptation to think that a patient's records are too detailed. Detailed records, however, may not be looked upon lightly, but must be prepared and examined in accordance with the standardization requirements of the American College of Surgeons, as well as in the light of their diagnostic, clinical and legal possibilities.[4] It is not properly the task of the record librarian to seek information to complete the charts which come to her office, and this expenditure of time on her part is not justified.

Metropolitan Hospital Chosen for Demonstration School of Nursing

The Canadian Nurses Association has announced, through its Educational Policy Committee, the selection of the Metropolitan Hospital, Windsor, Ontario, as the clinical centre for its new demonstration school of nursing. This school is to be operated upon a financial basis independent of its parent hospital, the hospital being relieved of all expense in connection with the operation of the school but in return paying for the services of the student nurses. This experimental study has been described on previous occasions in these columns and the costs of making the study are being underwritten in part by the Canadian Red Cross Society.

Miss N. D. Fidler, who has been on the staff of the University of Toronto School of Nursing and for the past year has been president of the Registered Nurses Association of Ontario, will be Director of the school.

Applications from suitable prospective students for the initial class, which will be admitted early in 1948, should be sent to Miss Fidler in care of the Canadian Nurses Association, 1411 Crescent Street, Montreal.

Improving Ward Efficiency

The ward is a busy place, and the duties to be done there, the difficulties to be met in doing them, are legion. However, the activities of the ward may often be performed more thoroughly and expediently than is now the case. The reason for this may be that there is unnecessary overlapping and duplication of effort. The only effective way to meet this situation is to undertake a *job analysis* of the duties of each individual on the staff, and outline the services for which each one is responsible. Another and underlying cause may be found in the physical characteristics of the unit itself. A tremendous amount of time and energy may be wasted by haphazard choice of supply rooms; nursing service suffers as a result. In an attempt to relieve this, many hospitals have set up *central supply rooms.*[5] With individual adaptations, this system has been beneficial to all who have experimented with it. The advantages may be summed up as follows:

1. It keeps equipment and procedures uniform.

2. It saves time and effort for the members of the nursing and medical personnel.

3. It keeps equipment in constant use and working for the hospital.

4. It makes it possible to equip hospital divisions with a minimum quantity of supplies.

5. It provides a place to care for equipment properly, and keeps it available for immediate use.

6. It reduces overhead cost of maintenance.

7. It serves as an experimental laboratory in simplifying technics and developing new ones.

8. Finally, it contributes to the educational program of student and graduate nurse.

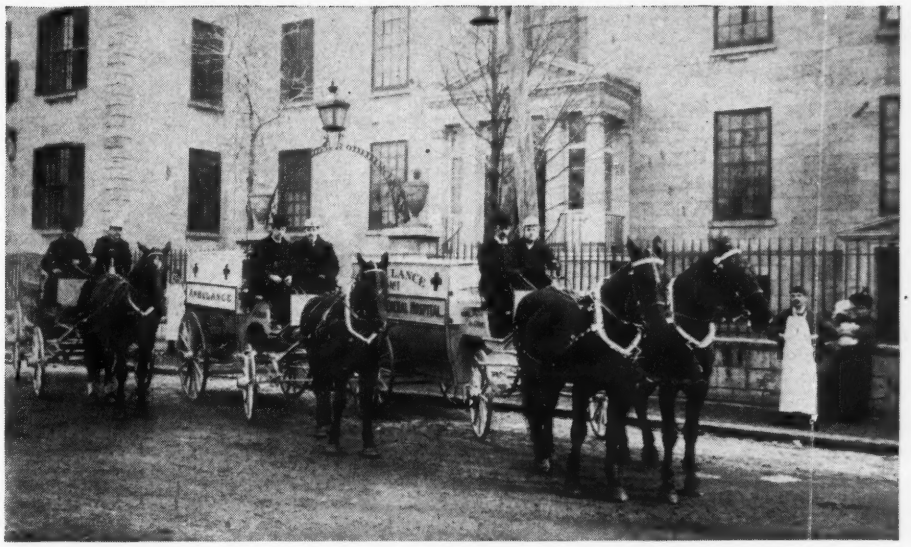
The effect upon nursing service of *telephone facilities and control* is an ever-present problem. Shall it be the duty of floor nurses to answer telephones? Shall inquiries concerning patients' conditions be directed to the floors? Shall private patients be permitted unrestricted use of the telephone? And so on. Solutions of some of these problems have been arrived at through the use of floor secretaries who attend to telephone calls, through directing many types of messages to an information bureau rather than to the floors; through the installation of the radiophone, for contacting individuals directly; in some instances, the services of qualified volunteers and nurses' aides have, to some extent, relieved this difficult situation.

Somewhat allied to this telephone

(Concluded on page 66)

4. Hospital Progress, Sept., 1945, "Medical Records—Through an Active Record Committee of the Staff", by L. J. Storry, M.D.

5. American Journal of Nursing, June, 1942, "Centralization of Supplies", by Wilkinson and Clow.



In the Good Old Days.

125 years of healing paces the growth of a city's achievements

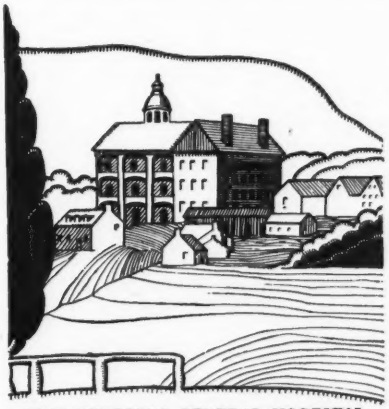
Yeoman Service of

The Montreal General Hospital

— A Career of Greatness

THIS year a great Canadian hospital observes one hundred and twenty-five years of service to the sick. The growth of The Montreal General Hospital from a 72-bed institution in 1822 to a hospital of 641 beds with extensive teaching and research adjuncts is one of the finest achievements of Canada's largest city. It is an epic story developed from the humanitarian recognition by a small group of public-spirited citizens of the imperative health needs of a rapidly increasing English-speaking immigrant population, among whom appalling sickness and poverty were prevalent.

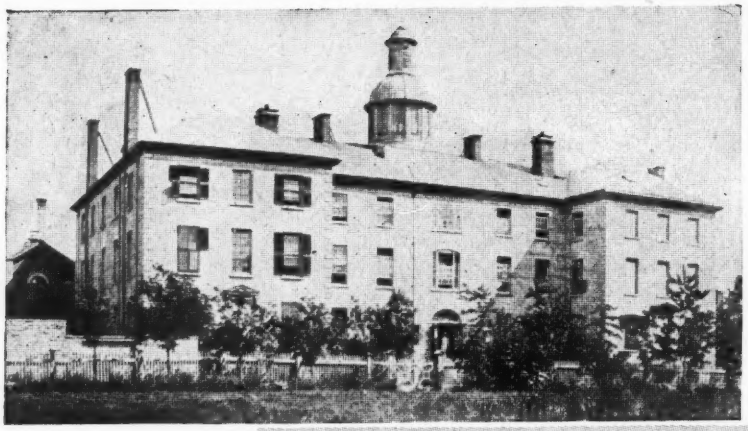
In those early days the facilities of the hospital, dating from the old French regime, were quite inadequate for the population of some 20,000 inhabitants. To provide facilities for the care of the sick, many of the cases arising out of the influx of immigrants which followed the Battle of Waterloo, an organization, called "The Female Benevolent Society" for the care of the Protestant indigent sick, was formed. Among the charitable endeavours of this society



THE MONTREAL GENERAL HOSPITAL IN 1832

was the establishment of a small four-roomed cottage in the present Chaboillez Square and dignified by the name "The House of Recovery". One year later, in 1820, a larger building situated on Craig Street was purchased by a group of businessmen, and became the direct lineal descendant of the present Montreal General Hospital. Bedding for the twenty-four beds was supplied by the army commissary-general, Isaac W. Clarke, who was the hospital's first president. This hospital was provided with a code of regulations and an attending medical staff, and "one Dr. John Stephenson was installed as house-surgeon to visit the hospital every day in case of accidents".

Events moved quickly as the necessity arose for further hospital services. One year later a larger site on Dorchester Street East was bought by private generosity; on June 6,

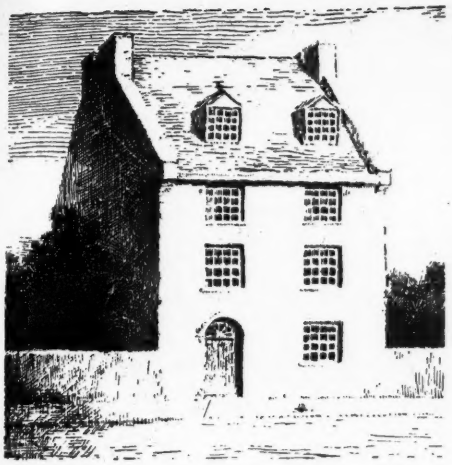


CENTRE: *A general view of the imposing 641-bed institution as it stands today—a far cry from the 1822 model, the first Montreal General Hospital.*

BOTTOM LEFT: *The attractive structure where today's nurses at the Hospital are housed faces the hospital.*

BOTTOM RIGHT: *The Private Patients' Pavilion entrance at Closse street in the Western Division block.*

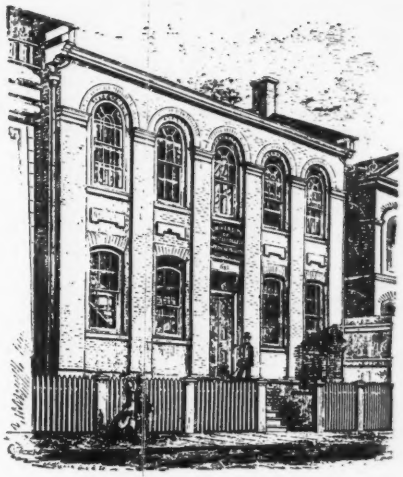
By 1848 the hospital had been extended, as above. The original hospital of 1822 is the centre building here upon which the cupola rests. The small building at the extreme left rear was used for the purpose of housing cases of smallpox.



LEFT: *"No. 20 St. James Street," believed to be the first home of the Montreal Medical Institution and the medical Faculty of McGill University.*

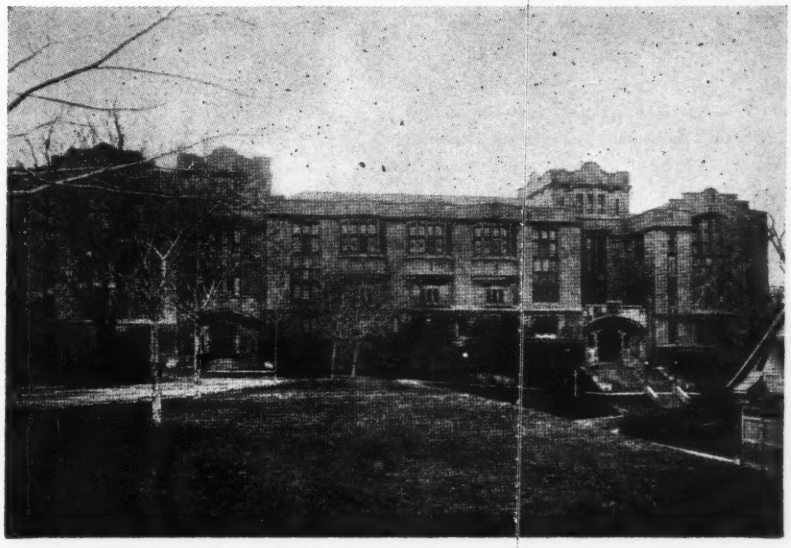
RIGHT: *The Cote Street Building, occupied by the McGill Faculty of Medicine from 1851 to 1872. William Osler graduated from this building.*

BELOW: *The Medical Building, McGill University, Montreal.*

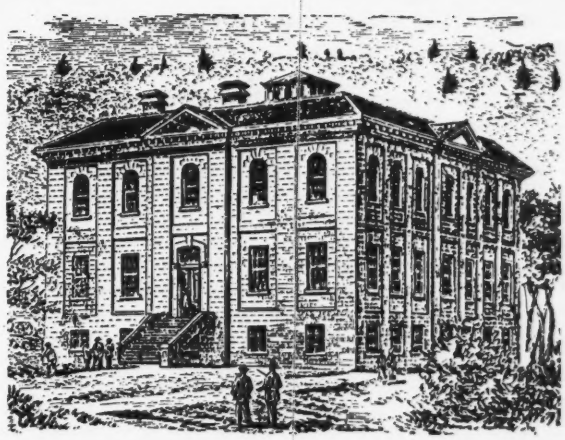


1821, the cornerstone was laid, and on May 1, 1822, the central block of the present building, erected by public funds, was opened for the admission of patients. The original building is still in existence and houses the administrative offices of the Central Division of the hospital.

The two buildings — one in the old section of the city, the other, the imposing structure of today — measure the growth of hospitalization throughout the years. Both are monuments to vision; the vision of men who foresaw the need for more hospital accommodation and allied their faith in the future with the determination to meet the immediate needs of the community. Prominent citizens, such as the Hon. John Richardson, the Hon. William McGillivray and Samuel Gerard, undertook the initial venture in 1822 and since that time generous Montreal citizens have given their support. Succeeding generations have maintained an active interest in the institution and through this support the clinical and other facilities have been made available to the famous doctors who have made the name of the Hospital known wherever medical research is carried out. A recent announcement has been made of the plans for a great research institute adjacent to McGill University which will deal with cell metabolism, a fuller study of which promises to throw new light on the cancer problem.



RIGHT: *The first building of the McGill Medical Faculty in the University grounds. Erected in 1872, it was destroyed by fire in 1907.*



The Montreal General Hospital has never lacked men of responsibility on its board of directors or in its medical services. On the roster there is the name of Sir William Osler, who as a young physician distinguished himself by being both doctor and patient, for he contracted smallpox while treating cases when this disease was endemic. At the Montreal General Hospital, Osler began the course of study and writing that made his name one of the greatest in medical history. Other names of note have preceded, accompanied and followed Osler—R. P. Howard and his son, C. P. Howard; Sir Thomas Roddick, who first employed antisepsis in Montreal; F. J. Shepherd, Wyatt Johnson, John McCrae,

(Concluded on page 100)

Is a Routine ADMISSION

CHEST X-RAY PROGRAM

Desirable for Public Hospitals?

S. A. Holling, M.D.,
Division of Tuberculosis Prevention, Ontario Department of Health

THE discovery of unsuspected cases of pulmonary tuberculosis by means of mass x-ray surveys of the apparently healthy general population has now become an accepted part of an adequate tuberculosis control program. As approximately 10 per cent of our population is admitted annually to general hospitals, the extension of such a service to this large, easily accessible group, offers an ideal opportunity for still further improving case finding methods.

It has been recognized for some time that tuberculosis in public hospitals is a problem requiring special consideration. The admission of unsuspected infectious cases of tuberculosis is a menace, not only to the hospital personnel but also to other patients, especially children who have not been previously infected. Due to close contact, the incidence of infection among student nurses as demonstrated by the tuberculin test, rises much more rapidly than that for similar groups elsewhere. The American Hospital Association reports that in the United States, the incidence of infection (positive tuberculin reaction) among student nurses on entering training is about 20 per cent in rural areas and fifty per cent in urban districts, rising to 40 to 50 per cent and 80 to 100 per cent respectively during their course. In the Province of Ontario for the calendar year of 1946, 18 per cent of students starting their training reacted to the tuberculin test, while on graduation the majority were reactors. In Ontario the incidence of active pulmonary tuberculosis among undergraduate nurses was .55 per cent for 1946 as compared to .17 per cent found among females of approximately the same age group in mass surveys conducted by the Division of Tuberculosis Prevention, Ontario Department of Health, during the first six months, 1947.

Members of the non-professional hospital ward staff may also show an increased incidence of tuberculosis depending on the duration of unprotected contact with infectious patients.

Value of Routine X-ray

The value of a routine chest x-ray of hospital admissions has been amply demonstrated by the results in a considerable number of general hospitals in the United States where such a program has been in effect. Such a procedure has been shown to:

(a) Discover cases of active tuberculosis, a large percentage being in the early stages;

(b) Uncover many significant symptom-free non-tuberulous chest conditions;

(c) Shorten the stay in hospital of a considerable number of patients, either by early diagnosis or ruling out of significant chest condition;

(d) Provide protection of hospital personnel, especially nurses and attendants, against tuberculous infection;

(e) Materially increase the diagnostic efficiency of the hospital medical staff.

There is now available a considerable amount of information as to the incidence of significant tuberculosis disease among hospital admissions. A study of the data published by the American Hospital Association indicates 1.5 per cent to 4.3 per cent, while the United States Public Health Service reports the average incidence as twice that of the general population in the United States. Of special interest is the recent report by E. M. Medlar, M.D., Mt. Kisco, N.Y., of an analysis of 14,719 autopsy findings in a number of general hospitals in the greater New York area for the two periods 1916-1920 and 1940-1945. Despite the removal of the majority of recognized cases of tuberculosis there was a residue of approximately 10 per cent of patients with pathologically significant tuberculosis.

The routine chest x-ray examination also discloses a large number of significant non-tuberculosis chest conditions such as abnormal hearts, new growths, a typical pneumonia, et cetera, a large percentage of which is unsuspected. A study of the literature indicates that approximately 10 per cent to 20 per cent of those examined in various hospitals had such findings.

The percentage of significant findings in this program is much higher than that found in the universally accepted routine blood count, urinaysis or blood serology. Therefore, from the standpoint of effective clinical diagnosis, the routine chest x-ray examination is more productive in the amount of unsuspected pathology discovered than any other one procedure.

The experience gained from mass x-ray surveys of the general population using x-ray equipment adapted for the use of miniature films has demonstrated that similar equipment

is admirably suited for a hospital routine chest x-ray program. Operation is simple and the cost per person examined low. Over sixty general hospitals in the United States have already introduced this procedure, and many more plan to do so as soon as the miniature film x-ray equipment is available.

In the past there has been considerable discussion as to the accuracy in locating chest pathology in miniature films as compared to the standard 14″ x 17″ film. Under the auspices of the United States Public Health Service and the U.S. Veterans' Affairs Bureau, careful study has been made of this problem. In each instance the reports were the same, viz., that chest pathology could be detected equally well in small films.

To utilize fully all the potentialities of a hospital mass radiography program, it should extend beyond the confines of the hospital and be an integral part of the over-all community tuberculosis control program. A general realization of this fact will ensure the co-operation of official and voluntary health agencies which may be expected to assist in financing the cost of equipment and operations.

The decision as to whether miniature film x-ray equipment can be efficiently operated in a given hospital should be based on the average daily number of miniature chest films which might be expected to be taken, rather than only on the number of hospital admissions. This service should be available for groups outside the hospital, such as tuberculin reacors among the high school population, pre-natal cases, and sections of the population among whom the incidence of tuberculosis is high, such as diabetics. In certain instances, hospitals have also contracted with industrial management to do pre-employment chest x-ray examinations.

Where Feasible?

Miniature film x-ray equipment in general hospitals where the daily average would be less than ten chest films is not recommended by those experienced with this program in the United States, as the volume of work does not warrant the expense for equipment. In such hospitals the program can be more cheaply carried out by using the existing x-ray facilities for standard 14″ x 17″ films.

In those hospitals with an estimated daily average of ten to thirty chest films, the present x-ray tube, standard and controls may be utilized with the addition of a camera, stand and photo-electric timer. Only a small amount of space (approximately 4′ x 6′) is required for this extra equipment, which may be readily moved out of the way when not in use. The cost of this installation is approximately $4,500. When an *average of over thirty films* will be taken each day, a complete miniature film x-ray unit is recommended, the cost being between $10,000 and $12,000, depending on whether or not a motor drive for the synchronous raising and lowering of the tube and camera unit is included. Expense may be saved by eliminating this, dependence being placed on manual operation where less than a daily average of 75 chest films is taken.

New Appointment

L. N. Hickernell, who assumed his duties on Sept. 1st, as superintendent of the Vancouver General Hospital, following the resignation of Dr. A. K. Haywood.

The unit should be located in or as near the hospital admitting office as possible in order that patients may be x-rayed without delay before going to the wards. As the equipment takes up a space only 3′ x 10′, a small room may be utilized. Failing this, it could readily be set up in a wide corridor. Patients are not required to remove clothing in this procedure, consequently dressing cubicles are unnecessary. Due to the automatic features of the equipment, taking miniature films is a comparatively simple procedure and members of the admitting staff can be trained quickly in the proper technique.

Processing and Interpreting

Processing the films would be the responsibility of the technical staff of the x-ray department. In the event the average daily case load exceeds sixty chest films, additional assistance might have to be provided.

All miniature films should be processed, interpreted and reported within twenty-four hours of their being taken. Usually a definite period of an hour or so each day is set aside for this work. In order to conserve time, the method of reporting miniature chest films should be as simple as possible.

In most hospitals using miniature films, a detailed description of the abnormal shadowing is omitted, only the suggested diagnosis being checked from a printed list of pathological chest conditions with recommendations if necessary for further radiological study with 14″ x 17″ films. If the film is negative, this is indicated by a check in the space provided.

The reporting of miniature films in those hospitals with staff radiologists offers no problem. However, in others, arrangements will have to be made with a private radiologist or chest specialist in the vicinity to interpret the films on a fee basis.

Costs

A study of operating costs for hospital miniature chest film programs in the United States indicates that the average approximate cost per person examined is up to 20 cents, exclusive of depreciation of equipment, technicians' salaries or radiologist's fees. These latter should b eestimated on a work-hour basis. The total gross operating cost, including depreciation, should not exceed 50 cents per person.

The method of payment for equip-

(Concluded on page 93)

Sudden Disruption *of the* Postoperative Wound

Joel W. Baker, M.D., F.A.C.S.,
The Mason Clinic,
Seattle, Washington.

THE sudden disruption of the abdominal wound creates a dramatic emergency. The patient is alarmed, the family are anxious and may be suspicious, and the hospital and surgeon occupy for the moment the spotlight of critical scrutiny. This represents, then, an acute emergency which arises after the patient is already in the hospital and, to the laity, it may even seem that the hospital is at fault and responsible for the accident which, to say the least, delays the recovery of the patient, increases his hospital expense and delays his return to gainful work.

It behooves the hospital, therefore, to have an organized plan for handling this condition with dispatch and to reduce, thereby, the anxiety and danger for the patient. This responsibility is divided between the professional staff and the hospital management. As a member of our hospital Board of Trustees as well as a surgeon demanding proper facilities of the Board, I represent both parties in this discussion. The ideal treatment is prevention, and careful thought should be focussed in this direction.

Prevention

How can the incidence of wound disruption be reduced? The surgeon must stay abreast of physiological factors demonstrated to have an influence in wound healing. To apply this at the bedside, hospital management must afford *dependable* laboratory facilities. For example, malnutrition, especially as it is reflected in a lowered serum protein, or in a reversal of the normal albumin-globulin ratio, is now appreciated as one of the most important factors influencing wound healing. The laboratory evaluation of the serum protein level and A:G ratio are dependable guides as to this deficiency and are not so complicated that any hospital handling referred surgery should not be expected to offer this facility. The deficient patient will require the services of a *dietary department* which is experienced in serving a palatable diet high in protein and the essential amino acids, and the competent surgeon will not do elective surgery in patients debilitated by chronic illness without such preparatory period. Adequate nutrition is but one factor. Another of importance is the correction of anaemia by blood transfusions before, during and after operation. In the anaemic patient any available protein is used to build the more vital oxygen-carrying haemoglobin rather than in healing the wound as the need for circulating oxygen represents a higher priority in the body economy than does the unhealed wound. Hospital management should lead in developing blood banks to supply this need for their patients.

Other factors impairing wound healing and which require laboratory facilities for detection or evaluation are: (1) avitaminosis, particularly vitamin C, without which collagen cannot be formed to bridge the incisional space between the wound edges; (2) jaundice and deficient prothrombin values which lead to bleeding in the wound; (3) uncontrolled diabetes mellitus; and (4) impaired renal function. The detection of such impaired physiological states reflects the ability of the professional staff and the competency of the laboratory, and when present must be combated before the surgical incision is made. Then it will not disrupt.

Infection weakens the wound. This introduces another aspect for discussion. Where infection already exists or is anticipated, the able surgeon will plan the incision and use a closure designed to compensate for this. Steel sutures, either buried or exteriorized, are favoured here since they interfere least with wound healing, and also because unlike silk or cotton they cannot harbour bacteria and perpetrate the infection. Infections developing in clean wounds are referred to as "institutional infections", a term which points an accusing finger at the surgeon or the personnel in the operating room. Since such infection is not anticipated, measures to combat its detrimental effect on wound healing, such as steel sutures, may not have been executed and disruption may more easily result. Certain technical considerations enter into the efficiency of wound healing as well as the incidence of wound infections, such as protection of the incisional edges from soiling during the intra-abdominal procedure, the degree of trauma, the approximation of tissues with accuracy and without tension, haemostasis, obliteration of dead space to prevent collections of serum, protection from prolonged exposure to the air, et cetera. On the part of hospital management this entails anaesthetists who can safely supply surgical planes of anaesthesia to permit proper approximation of tissues without tension, trained operating room personnel, conscious of the seriousness of their responsibility and organized by rigid discipline to handle crisis. *A surgical committee* selected from the professional staff to advise in the selection and purchase of skin antiseptics, proper quarantine packs, suture material and the like, divides this responsi-

Presented before the Hospital Conference of the Sectional Meeting of the American College of Surgeons, April, 1947, Vancouver, B.C.

bility in a desirable manner between hospital management and the staff.

Certain physical states also influence wound healing, such as early ambulation, severe cough, position in bed, straining at stool or with enema, an unguarded fall from bed, et cetera. I am among those who believe that early ambulation does not affect adversely the healing in a properly closed wound. Patients with incisional drains or infection should be kept in bed. The coughing patient should have his wound guarded by a proper binder and the cough should be treated. The position of the patient and the administration of the enema require experience that can be gained only under supervision. Semiconscious or deranged patients should have protective side rails, to prevent falls in the unguarded moment.

A case to illustrate the selective prevention in the vulnerable patient and the part played by the correlated efforts of all concerned might be appropriate:

A 55-year old policeman was brought to the hospital in an emergency for a continued haemorrhage from peptic ulcer. Immediate treatment included multiple whole blood transfusions, a special protein diet administered every two hours day and night, and laboratory studies to determine protein and fluid balance. After four days, despite the use of 18 pints of whole blood, he continued to bleed and an emergency gastric resection was done, during which time the patient was in a critical state. Because the preoperative studies had demonstrated not only an anaemia, but also lowered serum protein and vitamin C levels, all of which are factors delaying wound healing, a special type of closure with through-and-through steel sutures was used, and furthermore a catheter jejunostomy was done to permit direct feeding of protein digests and vitamin formulae. This, plus intravenous amino acids, blood and plasma, successfully combated the nutritional imbalance. The eventual clean, firm healing of his wound was the reward. Failure in any detail could have ended in disruption of the wound. Ulcer patients have a high incidence of disruption.

An instance in which failure to account for all factors proved disastrous is equally illustrative:

A 58-year old woman was operated upon through a lower midline incision for a carcinoma of the ovary. Upon exploration this was found to be irresectible and only a biopsy was done. Since x-ray irradiation will often control this type of growth for a long period of time it was mandatory that prompt healing of the wound be assured so that little time would be lost before treatment could be started. Therefore, because of the malnutrition, the lowered serum protein values and other factors present, it was elected to close the operative wound with through-and-through exteriorized steel sutures. On the fifth post-operative day the house physician failed to distinguish these from the usual skin sutures normally removed at this time, and he removed these steel sutures then, rather than leaving them until the twenty-first post-operative- day when wound healing could be expected. The patient promptly developed, four hours later, a disruption of the wound with evisceration of all the lower abdominal contents necessitating a second wound closure in the middle of the night. While firm wound healing ensued there was an unnecessary operation, a delay in administering x-ray irradiation, and the subjection of the patient to an extra anaesthetic, plus all the risks of infection and peritonitis with its possibly fatal consequence.

To prevent this mistake we now write in ink on the adhesive dressing

(Concluded on page 90)

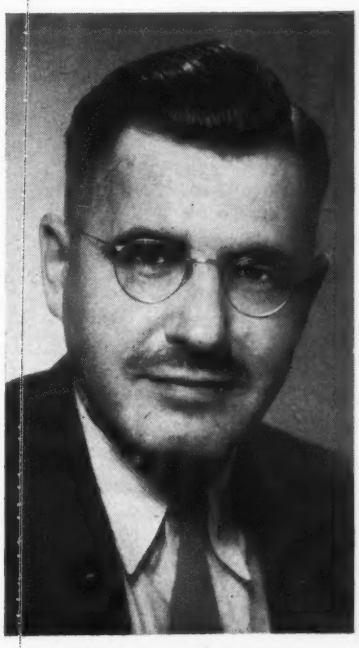
Change in Directorship at Toronto Hospital, Weston

M. J. McHugh, M.D.

Dr. M. J. McHugh, for many years superintendent of the Toronto Hospital at Weston, retired on September 2nd and has been succeeded by Dr. C. A. Wicks, formerly director of the Gage Institute in Toronto.

Dr. McHugh was graduated from the University of Toronto in 1921 and has been connected with the Toronto Hospital ever since an undergraduate medical student. Throughout the years he has been active in the hospital field generally and in various phases of social service. At present Dr. McHugh is first vice-president of the Ontario Hospital Association, a member of the board of management of the Ontario Plan for Hospital Care, and a director of the York County Children's Aid Society. He is a past president of the Weston-Mount Dennis Rotary Club and chairman of the Crippled Children's Committee in Rotary.

Dr. Wicks, a 1930 graduate of the University of Toronto, was with the provincial department of health for nine years and then superintendent of Brant Sanatorium in Brantford until joining the R.C.A.F. As director of the Gage Institute, he supervised the free chest x-rays given by the National Sanatorium Association. Many large industrial x-ray surveys have also been under his supervision. In addition to his new duties, Dr. Wicks will retain an interest in the general policy of the Gage Institute chest clinic.



C. A. Wicks, M.D.

Important Topics for Discussions at Winnipeg Meeting

Canadian Hospital Council to Hold Three-Day Session

MANY subjects of vital importance to hospitals have been planned for the biennial meeting of the Canadian Hospital Council to be held in Winnipeg, Thursday to Saturday, October 16-18. All sessions are being held at the Royal Alexandra Hotel.

As this is really the "Parliament" of the hospital associations and conferences, and is concerned primarily with the clarification of viewpoints and the establishment of principles and objectives, formal addresses as such will not be featured. The program in the main will centre about panel discussions of selected subjects with all delegates entitled, and urged, to participate freely in the discussions. Representatives of allied organizations will be present by invitation and, it is hoped, will add materially to the value of the discussions by their contributions.

According to present indications, all associations and conferences and the various federal and provincial health departments will be well represented. Quite a number of guests are expected, for the discussions are always of interest to anyone connected with hospitals. It is again emphasized that guests, engaged in hospital work, will be welcome, although the ballot will be restricted to official delegates or their alternates.

A feature of this year will be a dinner on Friday evening, the 17th, now being arranged by Dr. O. C. Trainor and his committee.

All planning to attend are urged to make hotel reservations as soon as possible.

Tentative Program

Thursday Morning, October 16th

9.30 a.m.—Registration.

10.30 a.m.—Call to Order.

Roll Call of Delegates..

Review of Present Situation—A. J. Swanson.

Report of Activities—G. H. Agnew.

Business arising out of report.

The Council's Finances—A. L. C. Gilday.

Thursday Afternoon, October 16th

2.15 p.m.—Shortage of Nurses and Other Personnel.

(a) Causative factors;

(b) Possible reassignments of duties;

(c) The Practical Nurse — her place, training, licensing;

(d) Educational policies for nurses;

(e) Nursing services other than in hospitals.

Chest Filming of all Patients.

Feasibility, value, cost, methods of financing.

Education for Administration (if time permits).

Institutes — Conventions — University.

Friday Morning, October 17th

9.30 a.m.—"The Canadian Hospital".

Hospital Finance.

Capital Cost—How meet?

Operating Costs—

Have all sources of revenue been adequately explored?

Care of indigents.

Care of out-patients.

Care of Indians.

Payment by D.V.A., Blue Cross and W.C.B.—Flat rate—going rate — actual cost — points of credit.

Personnel—To what extent should hospital hours be shortened, wages increased, working conditions revised?

Should Unionization be encouraged? If so, with what limitations?

What bodies should be considered as the Bargaining Agents? Under what conditions?

Income tax on married Women's Incomes.

Friday Afternoon, October 17th

2.15 p.m.—Health Insurance Period.

Voluntary hospital and medical plans.

State-sponsored plans — Alberta, Saskatchewan, Manitoba.

What is the future of the Voluntary Hospital?

Hospital Care for Rural Areas.

What types of facilities are needed?

How can these results be obtained?

Control of Surgery.

Blood Services.

The Red Cross undertaking.

The Care of the Chronically Ill (if time permits).

Friday Evening, October 17th

6.30 p.m.—Dinner.

Toastmaster—Dr. O. C. Trainor.

Address—(being arranged).

Saturday Morning, October 18th

9.30 a.m.—Progress in Accounting—Percy Ward.

The New Manual—Discussion led by Jas. C. Brady.

Pension Plans for Hospital Employees—

Report of the Special Committee —F. D. Beauchamp.

Improving the Work of the Associations—

Services to Hospitals — Regional Conferences — Local Councils — Women's Aids Section.

Revision of the Constitution—Judge J. M. George.

Saturday Afternoon, October 18th

2.15 p.m.—Hospital Construction.

When should we build?

What type of construction?

Are our buildings too elaborate?

Regulations re Shielding of Electrotherapeutic Equipment.

Resolutions.

Revisions of Study of Hospital Legislation.

Election of Officers.

The Hospital —KEYNOTE *to National Health*

Leigh J. Crozier, B.A., M.D., C.M.,
Superintendent, Victoria Hospital, London, Ont.

THE hospital has been called the keystone in the arch of national health. If the task of maintaining and improving the national health is to be performed in the future with effectiveness, hospital officials and trustees must be fully aware of the hospital's role.

Medical science is rapidly advancing. Citizens are demanding the highest standards of medical and nursing care. The hospital is the medium through which this knowledge is made available. Therefore hospitals must initiate many new methods, discard others and reapply older ones to new days and situations. Hospitals everywhere must realize that modern science and technology which are changing our manner of living are also affecting the whole program of hospital service, its financial resources, and the facilities employed in the prevention and care of disease.

The general improvement in the educational level of the people is leading to a better understanding of the value of health and the prevention of disease. The great increase in subscribers to the various forms of prepaid hospital insurance plans, as well as more recent steps taken by doctors to have prepaid medical and surgical plans, testify to the growing interest of the people, both lay and professional, in national health. To meet the steadily increasing demand for hospital beds, many new hospitals will have to be constructed and many existing ones altered or extended.

The cost of ordinary commodities used in all hospitals is increasing. An instrument that formerly cost forty dollars, now costs seventy. The cost of building material is excessive. If the hospital is to attract and maintain an efficient staff, it must be prepared to compete with industry in wages, hours and working conditions. Every hospital superintendent and trustee knows that the increased facilities and intensified treatment procedure has doubled the number of workers required. It takes six additional nurses on the staff of Victoria Hospital to give an average of 400 injections of penicillin in any twenty-four hour period. This all adds to operating costs. How then can the hospital continue to give the best service and, at the same time, meet its growing financial responsibilities? There will have to be worked out some financial assistance that will guarantee to the hospital the actual cost of treating all patients. The answer, I believe, remains with the municipal, provincial and federal governments.

Knowledge concerning disease prevention, early detection and treatment — for instance, of cancer — is widely spread. Through education Canadians must be taught the danger signals of cancer and the fact that early cancer can be cured, if the incidence of this disease is to be reduced. The demand for medical care and periodic health examinations will increase. Demands for early diagnosis and treatment will make increased facilities in hospitals more essential than ever. True, a considerable decrease in communicable disease is noted each year, but there are more cases of cancer and chronic illnesses on the wards than in former years.

Chronically Ill Need Care

The number of chronically ill patients is bound to increase. The housing shortage, the trend towards small homes and apartments, the lack of domestic help, and a growing tendency in younger age groups to shift the responsibility of caring for the aged to institutions, have all contributed toward placing more people with the diseases of old age in our institutions. Adequate accommodation for the chronically ill has not kept pace with the demand and as a result many are in general hospital beds. In addition to suitable homes for these patients, it would appear advisable that every general hospital over 200 beds should operate, in conjunction with its other services, a wing or unit for the chronically ill.

Food Habits Changing

Our food habits are changing, as well as our knowledge of nutrition. Malnutrition with low protein levels is seen in many of the ward cases. Millions of people in Europe are underfed, due to the aftermath of war. Research on the relationship of nutrition to disease will be carried on to a greater degree in hospitals. Frozen and dehydrated foods and a great demand for adequate refrigeration will require hospitals to provide more space and facilities, as well as a skilled and competent staff of food handlers.

In the hospital medical services there have been important advances in electric shock therapy, in the use of physiotherapy and in occupational therapy. Specialists in chest surgery request bedrooms equipped with suction and continuous oxygen therapy. Electro-encephalographs and ventriculograms for locating brain tumors and other intracranial lesions are advances which will directly affect the services of many hospitals. The increased demand for X-ray confirmation of clinical findings as well as the trend toward chest X-rays of all hospital admissions will require hospitals to provide this important department with greatly increased space, equipment and highly trained personnel. Medical science is "on the march" at a speed never before equalled. The hospital is the medium through which medical knowledge is made available to the farmer, the office worker and the man on the street. In many cases the distribution has to be made without adequate financial returns. If hospitals are to continue to meet the demands of modern medicine, then it is the duty of our citizens, through their governments, to see that hospitals are given the financial support required to maintain efficient service to the sick.

Obiter Dicta

Utilization of European Doctors and Nurses

AS part of the program for finding homes and work for displaced persons, attention has been focussed on the immigration of displaced doctors and nurses to meet the needs in this country. The federal government has been studying the question and is prepared to bring European doctors to Canada, if the provinces want them, and may facilitate the entry of nurses if desired. The bringing over of domestic workers is highly commendable, as is also the plan to give hospitals prior consideration in placing them. More care may be needed in bringing over nurses and, particularly, doctors.

Undoubtedly there is a need for both nurses and doctors, particularly the former, in many areas, but the simple landing of these people at a Canadian port will not alone solve the problem. The experience with refugee doctors has not been too favourable. The real need is for doctors in rural areas, yet many of the refugee doctors licensed during pre-war and war years in Canada and the United States are now practising, we understand, in cities where they are really not required. There is no shortage of doctors in urban centres. If the need of the rural areas is to be met, it may be necessary to issue special licenses valid only as long as they practise in rural areas. This would soon be attacked, of course, by certain political groups who would charge "discrimination", but it would be a help. It must be realized, too, that there is no grading of medical schools in Europe as on this continent. Some schools are excellent while others would have short shrift here. On this point the public would have little protection for licensing examinations alone do not assure an adequate background.

The standards vary even more so when it comes to nurses. Some schools have a very high reputation while others give a quite indifferent training. It is questionable if our hospitals could employ certain nurses who might desire to come other than as practical nurses or nurses' aides. In that capacity, however, they could be a real help, for it has been our observation that continental nurses are workers. Certain problems would arise respecting registration and it is presumed that graduates of schools not recognized as of a high standard would be required to take formal examinations to qualify for registration. The language barrier will be a serious one, unless they can speak French or English, and it is to be hoped that the government, if it brings these nurses and doctors over, will take steps to overcome this language handicap. If this can be done and steps taken to give the public reasonable assurance that these European nurses are competent, even though their methods may be dissimilar from ours, the program should be well worthwhile.

Unfortunate Publicity

MANY of the difficulties under which hospitals labour at the present time, particularly with respect to personnel, would be considerably reduced if more of the information made available to the public from various sources was more accurate and up-to-date. A recent example of this coming to our desk is a four-page pamphlet issued earlier in the year by the Royal Bank of Canada and entitled "Prospect of Health". There is much valuable information and many helpful observations and recommendations in this pamphlet, but it would have been more valuable if some of the source material had been more up-to-date. The reference to nursing is far from a true picture of the general situation to-day and cannot help but still further discourage girls from entering the field of nursing. The brief reference to nursing dealt only with the low salaries and long hours of duty in hospitals. The Canadian Medical Procurement and Assignment Board was quoted as reporting that 49 per cent of general duty nurses working in hospitals receive a salary of $849 a year or less. It was not noted that this was an old study made by the Canadian Nurses Association and first

published in March, 1943, since when the whole picture has changed materially. Nor is there any note that most of these nurses received full maintenance as well and that many general duty nurses are on a part time basis.

The rest of the section on nursing is devoted to statements in a booklet on health prepared several years ago by a committee of CAMSI for the Canadian Youth Commission and which received criticism as dealing inadequately with the topic and as presenting largely a socialistic viewpoint not shared by the organization as a whole. To quote the pamphlet again "Only 33 per cent of nurses were stated to be working 96 hours or less a fortnight. Some ranged as high as 160 hours a fortnight. One case, not isolated, was that of a nurse receiving $720 a year, without maintenance, and working 112 hours a fortnight."

It is statements like this which are quite obsolete, or which are drawn from isolated instances far from indicative of the prevailing situation, which have done so much to keep young women from coming into nursing. These figures were common enough during the depth of the depression years when nurses could not get work and hospitals—with large deficits and half of their private wards empty—put many nurses on full maintenance and small salary in order to give them some employment.

A recent spot survey of representative hospitals, large and small, rural and urban, across Canada earlier in the year, revealed that general staff nurses, except in the Maritimes, seldom received under one hundred dollars a month *with* maintenance, which at the present standards, would be around $45 to $60 per month additional, although usually set at lower figures, either to help the nurse on an income tax basis, or because of labour board stipulations. From this point incomes rapidly rise, depending upon departments and qualifications, to $175, $200, and up to over $300 per month. In addition there is a lengthy holiday with pay and numerous perquisites that are not given to women in other occupations elsewhere.

Actually, our hospitals pay more to nurses' aides, or practical nurses, than the figures quoted in this pamphlet. The same survey by the Council revealed that nurse aides are paid from $50 to $85 a month with maintenance. That the whole scale of salaries and wages has risen considerably even since the preparation of this material last winter is shown by a clipping on our desk at the moment, indicating that in one eastern hospital these short course nursing assistants start at $92.50 a month and increase to $95 after one year's service, plus one meal on each shift and extra payment for those on the evening and night shifts. This is for an eight-hour day and a 48-hour week.

It is somewhat misleading, too, to state that most of the hospitals in Canada are "privately-operated". We pride ourselves in this country that we have a lower percentage of beds in privately-operated hospitals than either the United States or Great Britain. Obviously the writer meant "voluntary" rather than private, the latter being a term which we use in Canada as synonymous with "proprietary". On the whole, this is an unusual compilation of excerpts, comments, press references and other material which seems to stress some comparatively minor details at the expense of major and more fundamental factors. One gets the impression that the writer either lacked much real knowledge of the subject or was content with limited source material.

To be fair to an institution which, with the best of intentions, has had some member of its publicity or medical staff prepare this material, it is only too true that very little material for public consumption has been issued by the professional or hospital organizations with intimate knowledge of the problems to be faced. Much has been written in medical and hospital journals but these are not widely read outside their fields. Reports on research seldom reach public libraries. Some of the most widely circulated health literature has been written from one particular political or social angle. If we wish the public to be well informed—and the Royal Bank of Canada is trying to do its bit—we should prepare more public literature ourselves—literature which would tell the story of each factor in national health with intimate knowledge, with practical proposals and without bias.

Rural Hospitals are Assets

AN example, by no means unusual, of the important place of a small hospital in the life of a rural community, is afforded by the story of Brooks Municipal Hospital — a fifteen-bed hospital serving the irrigation area east of Bassano, Alberta, between the Bow and Red Deer rivers. The work of this hospital was reviewed in a recent issue of a western farm periodical. Opened in September, 1943, during the first three full years 2,532 patients were admitted for a total of 19,728 patient days. By the end of 1946, 255 major and 735 minor operations had been performed. Opinion may vary as to the desirability of doing so many major operations in a fifteen-bed hospital, but the record does indicate tremendous activity. During 1946, the fifteen beds averaged 20.6 patients per diem. When the supply of reserve beds gave out during peak periods, couches and beds were borrowed from the neighbours.

An added advantage has been the attraction of the hospital for doctors. Prior to 1943 there was a period of several years when no doctor practised east of Bassano, except on intermittent occasions. Now there are three doctors in this vicinity in addition to those over at Bassano. Moreover, the hospital has not been a financial drag. The initial cost was $61,000, covered by a debenture issue of $55,000 and the sum of $6,000 paid from the first year's revenue. By the end of 1946 the books showed a surplus of revenues over expenditures of $5,000. Also $10,000 of the original debenture issue was paid back last year. A new addition to the hospital costing some $20,000 is to be added shortly. This is a record of which the community may well be proud.

D.V.A. Payments *to Civilian Hospitals*

IT WOULD appear that varying interpretations are being made of the arrangements by the Department of Veterans Affairs for payment to civilian hospitals for those services to veterans for which the Department may be considered responsible.

To clarify the situation the following outline of the arrangements has been prepared and has been approved by the Director General of Treatment Services.

1. The Department of Veterans Affairs will pay for the hospital care in non-departmental hospitals of former members of the armed forces, admitted under the doctor of their choice, provided that:

(a) entitlement to treatment by the department exists;
(b) departmental hospital accommodation is not available;
(c) the circumstances of the individual case call for hospitalization in other than a departmental hospital.
(d) it is otherwise in accordance with instructions circulated to all licensed medical practitioners.

NOTE: It is the responsibility of the veteran to establish entitlement. A veteran claiming assistance because of financial circumstances must establish his claim for eligibility through the district office. In centres where there is a departmental hospital, district authority for admission must be obtained. In areas where there is no departmental hospital, district authority must be obtained for admission for elective surgery and for other than routine treatment of conditions for which the Canadian Pension Commission has granted entitlement.

2. The type of accommodation for which the D.V.A. will be responsible in other than departmental hospitals is that which is at the lowest rate for non-departmental patients and where the patient may be treated by the doctor of his choice.

(The use of the term "public ward" has been discontinued and the term "general ward" has been adopted.)

3. The general ward only will be paid for unless the condition of the patient necessitates a semi-private or private bed, a decision which must be approved by the attending doctor, who must certify as to need; and the account must be approved by the Departmental District Medical Officer.

4. If a veteran wishes to use a type of accommodation other than that authorized by the Department, he must pay the difference himself.

5. The Department has agreements with a number of civilian hospitals regarding rates payable. These agreements cover general ward, semi-private, and private room charges on the understanding that the general ward will be used unless the condition of the patient requires a two- or a one-bed ward. The agreements list the items which shall be included without further charge and also those for which charges may be made in accordance with the departmental schedule of fees. The existing agreement form and schedule of fees, and also instructions to licensed medical practitioners, may be obtained by any hospital on application to the Department district office. Agreements may be reviewed for revision or termination at any time.

6. If no agreement between a hospital and D.V.A. exists (see No. 7), the Department pays the rate charged to non-departmental patients; such laboratory, dressings, and other services, to be included as would prevail in the case of such patients, and with any other items charged for as extras, in accordance with the D.V.A. schedule of extras and approved by the district office as necessary.

7. In two provinces, arrangements, other than the above, prevail:

(a) In Saskatchewan hospitals are classified on a "points of credit" system and payment is made in accordance with the rates established by the Saskatchewan Hospital Commission.
(b) In Alberta an arrangement has been worked out by the Department, the hospital association (Associated Hospitals of Alberta), the Workmen's Compensation Board and other bodies whereby hospitals are classified into groups depending upon facilities available (point basis) and payment made accordingly.

Services and Supplies Required in the Hospitalization of D.V.A. Patients

PART 1

Items INCLUDED in Accommodation Charges

(a) Routine floor nursing, as provided with ward accommodation, including the special attention that is given to seriously ill patients, but not the services of private duty nurses, which will only be paid for if authorized by the departmental district medical officer.

(b) Laundry, exclusive of personal laundry of the patient.

(c) Full intern service if interns are maintained at the said hospital.

(d) Ordinary medication, including saline and glucose injections and ordinarily prescribed pharmaceutical preparations, but not expensive medications, sera, vaccines or biological preparations.

(e) Laboratory services, including routine laboratory examinations, such as routine urinalyses, blood counts including differentials, blood sugars, throat swabs, sputum and gastric contents analyses, and Kahn, Hinton or Wassermann tests, but not those involving extensive investigations, unusual examinations or special studies.

(f) Dressings, splints and appliances as would ordinarily be provided on a ward service to paying patients.

(g) Anaesthetic material as provided by the hospital.

(h) Physiotherapy only as provided without charge to other paying

(See next page)

The Rev. Alphonse M. Schwitalla, S.J., Now President Emeritus, C.H.A.

THE annual convention of the Catholic Hospital Association of the United States and Canada, which was held in Boston in June, was marked by the formal retirement of Father Schwitalla who has for so many years been President of the Association. He will, however, continue to serve the organization as President Emeritus. Father Schwitalla followed the Reverend C. B. Moulinier as president almost twenty years ago and, in this capacity, he has made a great contribution to the hospital field in the United States and in Canada. During these years he has played an active part in presenting the views of the hospitals at Washington and elsewhere. As Director of the University of St. Louis School of Medicine, he has made notable contributions to medical education. He has co-operated wholeheartedly with the American Medical Association and other bodies in advancing the standards of medical education. Father Schwitalla was one of the group which drew up recommendations respecting formal training in hospital administration for the American College of Hospital Administrators. His editorials in *Hospital Progress* have long been a constructive feature of that magazine and his articles in the *Linacre Quarterly,* of which he is the editor, have been most valuable. Father Schwitalla has frequently attended meetings of the Catholic Hospital Conferences in Canada and of the Canadian Hospital Council.

The new President of the Catholic Hospital Association is the Rt. Reverend Msgr. Maurice F. Griffin of Cleveland, who for many years has served as Vice-President. Father Griffin has long been a senior trustee of the American Hospital Association and has been a tower of strength to that body in all its deliberations.

Officers

Other officers and members of the executive board elected at the Boston convention of the Catholic Hospital Association are as follows: *Honorary President and Spiritual Director* — His Eminence, Samuel Cardinal Stritch, Chicago. *President-Elect* — The Reverend George Lewis Smith, Aiken, S. Carolina. *1st Vice-President* — The Reverend John W. Barrett, Chicago. *2nd Vice-President* — The Right Reverend Msgr. John R. Mulroy, Denver, Colorado. *Secretary* — Sister Helen Jarrell, Chicago. *Treasurer* — Mother M. Irene, St. Louis, Mo.

Other Members of Executive Board — Sister M. Agnes, Oklahoma City; Sister Martha Mary, Brighton, (Boston), Mass; Sister Mary Rita, Denver, Colorado; Brother Leo, C.F.A., Chicago; Sister St. Elizabeth, London, Ontario; Sister M. B. Dorais, St. Boniface, Man. *Executive Director* — The Reverend John J. Flanagan, S.J., St. Louis, Mo. *Executive Secretary* — Mr. M. R. Kneifl, St. Louis, Mo.

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patients. Other physiotherapy shall be considered as an extra and shall be administered only on the authority of the departmental district medical officer.

(i) All other necessary hospital supplies which would ordinarily be provided on a ward service to paying patients.

PART 2

Items Chargeable as EXTRAS in Accordance With the Departmental Schedule of Fees

(a) Medicines which are not ordinarily prescribed but which are approved by the department in the interest of good treatment and which are relatively expensive.

(b) Laboratory examinations not considered as routine, including the following:

Blood urea, sedimentation test, Mosenthal test, fractional bile analysis, spinal fluid tests, sugar tolerance, stool examinations other than occult blood, inoculation tests, allergy, Mantoux and other special skin reactions, blood matching, tissue examinations, autogenous vaccines, guinea pig inoculations, urological dark field examinations, blood cultures, blood agglutinations, and other tests and studies.

(c) Blood transfusions.

(d) Intravenous therapy, other than routine saline and glucose, and arsenicals when the latter are provided by arrangement with the government.

(e) Physical therapy other than as provided under Part 1 (h) and which is administered only on the authority of the departmental district medical officer.

(f) X-ray diagnosis. and therapy.

(g) Basal Metabolism.

(h) Electrocardiograms. (Technical service only is required by the Department.)

(i) Orthodiagrams.

(j) Radium.

(k) Oxygentherapy and oxygen-carbon dioxide therapy. (Gases to be supplied at cost.)

(l) Professional service of the staff anaesthetist other than intern.

(m) Private duty nursing and nurses' board.

(n) Use of operating room.

"Nascopie's" Mission to Be Fulfilled

The last mission of the ill-fated *Nascopie* is being carried out. When the *North Pioneer* and the *Icehunter* sailed last month from Montreal for the Eastern Arctic they carried every essential item of medical and surgical supplies, food and fuel required to supply the needs of medical outposts in the far north.

More than 1,250 separate items were included in the shipments of food, provisions, equipment and fuel sent to the doctors and nurses in the northern region to assure them of adequate supplies for the coming year and a reserve stock for emergencies. Through the co-operation of the Hudson's Bay Company and all the contractors who supplied the goods lost when the *Nascopie* foundered, the Department of National Health and Welfare was able to duplicate ninety per cent of the original orders, and for the remainder of the items was able to obtain suitable substitutes.

In addition to the duplicate medical supplies for the northern stations an entirely new and modern surgical and medical kit was provided for the use of Dr. H. W. Lewis, Ottawa, regional medical superintendent for the Eastern Arctic. Dr. Lewis, who was on the *Nascopie,* returned to the north on the *North Pioneer.*

Comparison with Canadian Standards

British Society *Urges Greater Restrictions* on PROPRIETARIES

GREATER efforts are now being made in Great Britain to bring the sale and advertising of proprietary medicines under statutory control. In this effort the Pharmaceutical Society of Great Britain has taken the lead and has urged the Minister of Health to set up the necessary enactments and regulations.

It is proposed that there be a register of medicines and of manufacturers; that the sale of unregistered medicines be prohibited; that standards for medicines and their advertisement be prescribed, including the disclosure of composition in approved words, approved quantities, the prohibition of false, misleading or exaggerated claims and the prohibition of offers of diagnosis by mail; and that similar provisions apply to surgical appliances and "treatments".

The Society has submitted a 14,000-word report based upon a five-year study of the situation. Says the report: "Throughout the pages of most newspapers and periodicals in general circulation, sufferers from all manner of diseases and ailments are offered beans, tablets, wines, powders, salts, pills, ointments, tonics, hormones, glands and vaccines that will bring them youth, health, charm, slimness, strong nerves, inner cleanliness, lively livers, freedom from pain, increased (or decreased) weight, iron for the blood, purer blood, vitamins, contentment, resolution, immunization, vitality, and so on. The advertisers' claims are frequently so fantastic that one would not be surprised to find them offering secure jobs and large salaries into the bargain."

The Society noting the increased use of proprietaries after National Insurance came in prior to World War II, fears further extension under the broader health services now being proposed. "Unless, therefore, appropriate steps are taken to provide this protection, the era of a comprehensive health service may bring with it the golden age for commercialized charlatanism, which makes a butt of the orthodox practitioners on whom the service depends, and a victim of the public to the prejudice of the service. It is, therefore, desirable, before the compelling pressure of these selling methods can be exerted still further, to direct attention to the following conclusions which, it is suggested, are to be drawn from the facts set out in this report:

1. Proprietary medicines are advertised in terms of the grossest exaggeration, advancing claims which are frequently fraudulent.

2. The persistent and ubiquitous advertising of proprietary medicines makes the public conscious of disease, teaches that ill-health is the normal condition of human beings and encourages self-medication as a habit.

3. The claims made for some medicines lead to the public postponing seeking skilled advice and encourage symptomatic treatment, thereby prejudicing the success of treatment directed to the cause of the symptoms.

4. Many advertisements for proprietary medicines are based upon creating an atmosphere of fear — fear of ill-health or of an operation; of premature old age, of an incurable disease.

5. Reliance is based upon uncritical testimonials as evidence of the value of proprietary medicines.

6. Exaggerated claims are made for medicines for the relief of chronic conditions, such as asthma and rheumatism, and hopes are held out which cannot be realized.

7. By implication or indirectly the advertising of proprietary medicines undermines public confidence in a State medical service and in the registered medical practitioner at whose hands such a service must be provided.

8. Questionnaires are sent to patients with the suggestion that the manufacturers of the medicine will diagnose from the patient's answers what his complaint is and what medicine should be given him. These forms are sometimes never looked at and there is evidence that the same medicine is supplied without regard to the information which the patient gives.

9. Pamphlets and advertisements are published which advertise articles as sexual tonics.

10. Excessive prices and fees are charged for some medicines and for some treatments and money that can ill be spared is extracted from the sick.

11. Many advertisements are couched in scientific or semi-scientific terms, often meaningless or having a pretence to scientific advance, designed to impress or deceive uneducated and credulous people.

12. Endeavours are made to circumvent legal requirements relating to disclosure of composition.

13. Certificates of analytical bodies referring to qualitative and quantitative particulars are issued to proprietary medicine manufacturers on a commercial basis and are used by them in advertisement in implied support of claims concerning which the certificates have no relevance.

14. Preparations are compounded in a manner and of such substances as to defy analysis and preclude the production of evidence at law as to composition.

15. The advertising of proprietary medicines is so extensive that the influence of advertisers prevents the ventilation of reforms in the public press and so derogates from the principle of the freedom of the press.

16. The volume of advertising of proprietary medicines gives these articles a significance which is out of all proportion to their true value to the community."

The Canadian Situation

In this connection it may not be as widely realized as it should be how extensive have been the regulations and other controls set up by the

(Continued on page 78)

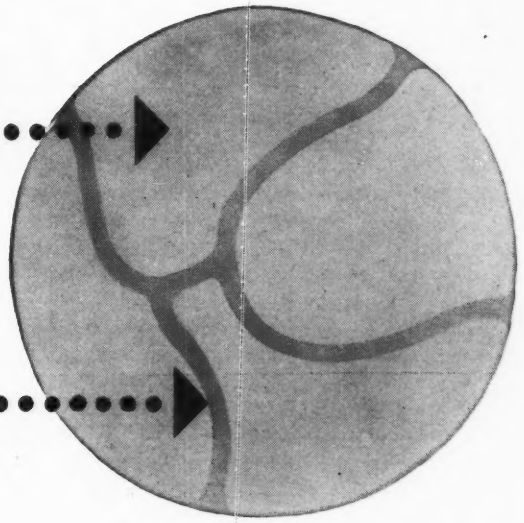
A New Curity Development..

REG. IN CANADA

TOTAL CHROMICIZATION

PLUS

NATURAL PLY ADHESION



200 x

Diagrammatic cross section of new Curity Catgut. Shaded area indicates even distribution of the chrome complex, from rim to centre of the strand. Heavy lines (emphasized for diagram purposes) show line of contact of component plies, bonded together NATURALLY with natural mucin. No adhesive is added. Curity Catgut thus keeps a long-standing advantage (natural ply adhesion) while gaining a new one (total chromicization)!

Curity Catgut Sutures have been further improved by a new chromicizing process that effects TOTAL CHROMICIZATION, *without sacrifice of* NATURAL *ply adhesion.* There is an even distribution of the chrome complex from rim to center of the strand—yet the firm, *natural* mucin bond has been retained completely.

The importance of a mucin bond

Mucin, a glutinous exudate of the catgut ribbons that form a suture, is the only *natural* bond between plies. The mucin bond is firm—and it is *increased* through chromicization. It is so strong that no foreign adhesive agent (a possible irritant) is necessary. Now, in addition to this long-standing Curity advantage, the new process gives you increased absorption control through total chromicization.

What this means to you

You now have, through the new Curity process, a superior suture to match your skill when you use Curity Catgut. Absorption is even *more dependable,* giving you greater control. Further, though the chrome complex is evenly distributed throughout the strand, the chrome *content* is lower than ever—reducing irritation even further. As to tensile strength, NO CATGUT SUTURE OF U.S.P. QUALITY AVAILABLE TODAY IS STRONGER THAN CURITY! Specify Curity Sutures for your next operation!

A Product of

BAUER & BLACK

Division of The Kendall Company (Canada) Ltd., Toronto, Ontario

Curity
REG. IN CANADA
SUTURES

Suture Research . . . To Establish a Fine Balance of Necessary Characteristics

Food and Its Service

Sponsored by the Canadian Dietetic Association.

Milestones in Nutrition

Anna S. McCann, B.A., B.Sc.,
Dietetic Intern,
Toronto General Hospital.

MUCH of the history of nutrition is found in stories of exploration, in reports of naval and military expeditions, and in the records of feeding problems in prisons. These seemingly odd sources provide valuable information because in each case a large group of men were kept under constant conditions and on a definite diet. Such reports and records often tell a tale of the effects of the diet provided. Then, too, scientists throughout the ages have recorded studies of food in its relation to health and longevity.

The field of food investigation dates back many years before Christ when Pythagoras advocated the exact measurement of food and drink. The *Apichus*, the world's oldest known cook book, dating from the Roman Empire, is filled with dietetic principles which are sound today.

One of the very early nutrition studies was made by Roger Bacon in the 13th century. Bacon investigated the effect of diet on old age and he claimed that the three main causes of senility were infection, neglect and ignorance. He believed that senility could be retarded by the proper blending of the food elements, but he could not get people to take an interest in it early enough.

In the 15th century Luigi Cornaro advocated a diet for the poor classes which consisted of bread, soup and an egg. For the more wealthy he suggested that meat be added. He also advocated temperance in all things if the person wanted to live to an old age. At the same time Stark, a Glasgow medical student, studied diet by experimenting on himself. He gave himself scurvy, and died of it, by living on bread and water. Stark studied the length of time it took for foods to digest by eating seeds with his meals. He also discovered that soft fats were better tolerated by the body than were hard fats.

During the 15th and 16th centuries scurvey was a major problem affecting all expeditions of discovery. While at Quebec on his second voyage, Cartier discovered the first antiscorbutic substance. His men were dying of scurvy; their legs were swollen and the sinews were black; their gums became putrid and fell away from the teeth. A post mortem examination of one body showed that the heart was withered and white and surrounded with water. The liver seemed normal but the spleen was badly ruptured. The Indians taught Cartier to make a tea from evergreens and to give this to the men.

Further voyages resulted in the discovery of grass, fresh vegetables and lemon juice as antiscorbutics. Cook felt that cocoanuts were good antiscorbutics, although we have since discovered that there is very little vitamin C in them.

All through the 17th century the problem of scurvy was studied. Lind advocated the use of citrus fruits as treatment for scurvy, to replace pills made of a mixture of soap, garlic and squill. He also suggested the use of soups made from celery, cabbage, leeks and onions. He was convinced that scurvy was not contagious. Lind advocated supplementing the existing naval diet of sea biscuit, pickled suet, oatmeal, peas and salt meat with butter, cheese, raisins and currants. He approved of the ration of beer which was given to the men. He found that orange and lemon juice were the most effective in curing scurvy, and that even the rind was effective. One seaman cured himself by the use of the rinds left from the officers' punch. Lind advocated the use of spruce beer as an antiscorbutic. He was in advance of the times in suggesting that environment had some effect on scurvy, pointing out that petty officers did not develop scurvy although they lived on the same food as the men did. He credited this to the fact that petty officers had canopies over their beds and therefore the beds were dry, while the beds of the crew were damp.

At this same time in England a famous nutritionist, Count Rumford, was reorganizing the feeding of the army. He recognized the value of fresh vegetables in the diet, especially potatoes, and he organized the men in a system of gardening. He succeeded in spreading his work to the country at large, for the men took this knowledge home when they left the army.

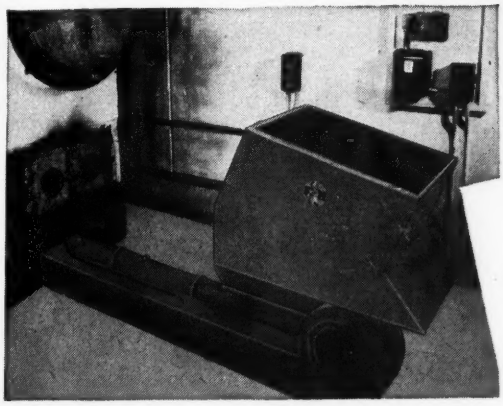
During the 17th century in France the inventor and scientist, Papin, discovered gelatin. He invented the forerunner of the pressure cooker and autoclave, and succeeded in making a gelatin from dry bones in this cooker. Papin experimented with the feeding of dogs on gelatin and found that when they were fed on it for several days they refused to eat it and died of starvation. Dry bones would sustain them but gelatin would not. Further experiments were carried out with egg albumin and also with such purified constituents as fat, gluten and starch. Gluten was found to be the best, keeping the animal alive for two months.

During the 17th century also the study of bone structure began. Hales, a clergyman, made a study of the growth of bones and discovered that

(Concluded on page 58)

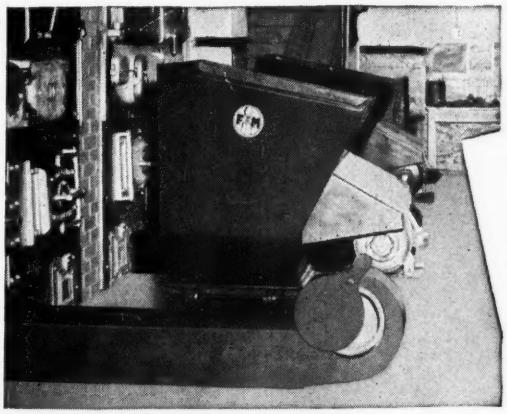
There's no Finer Recommendation than a Satisfied User

READ WHAT THESE OWNERS SAY ABOUT THEIR FAIRBANKS-MORSE *Automatic* COAL STOKER



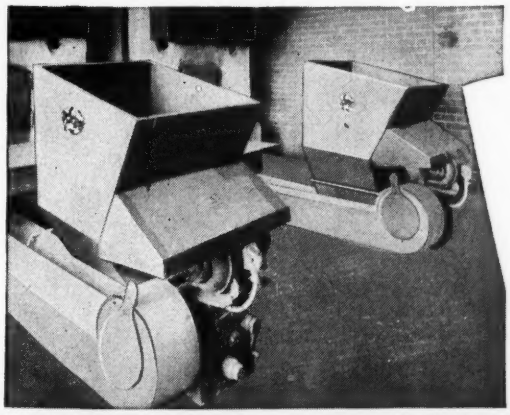
"The Fairbanks-Morse Stoker in our Our Lady of Mercy School at Sarnia, Ontario, is very satisfactory, and we do not hesitate to recommend it to anyone."

R. C. Separate School Board, Sarnia, Ont.



"Since their installation in our heating plant, the two Fairbanks-Morse Stokers have given entire satisfaction."

L'Ecole Technique, Three Rivers, Que.



"The two Fairbanks-Morse Stokers installed in our Hangar at Fort William have been reliable and efficient and have required very little repair and maintenance."

Canadian Car & Foundry Co. Limited, Fort William, Ont.

F-M Coal Stokers for industrial and commercial use are available in capacities from 50 to 500 lbs. of coal per hour. Get in touch with the nearest F-M Branch and find out how they will cut your fuel costs and increase your heating efficiency.

The CANADIAN **Fairbanks-Morse** COMPANY *Limited*

HALIFAX SAINT JOHN QUEBEC MONTREAL OTTAWA TORONTO WINDSOR
FORT WILLIAM WINNIPEG REGINA SASKATOON EDMONTON CALGARY VANCOUVER VICTORIA

With the Hospitals in Britain

By "LONDONER"

C. E. A. Bedwell

Dear Mr. Editor:

In the middle of the Parliamentary discussions about the future of the voluntary hospitals I ventured to declare my faith in the future of the maintenance of the voluntary spirit (see June, 1946). The celebration of the Diamond Jubilee of the Hospital Saving Association has provided remarkable evidence in support of my confidence. Twenty-five years ago when it was started there was some doubt about the possibilities of success. No one previously had attempted to build up an organization to cover the whole of the Metropolis, which has no corporate life and has been called the greatest "conurbation" in existence.

It is a comparatively simple matter in large cities like Liverpool and Sheffield, which have a strong local patriotism and only a small number of hospitals attracting the attachment of patients and their friends, to call forth their goodwill through a contributory scheme. But in the Metropolis those two foundation stones for an appeal are lacking, yet what has been the result?

In the first year of the H.S.A. there were 15,336 contributors. The income received from them was £2,716. In the middle of the greatest upheaval of the national life, which has ever occurred, the number of the contributors was raised to over two million and for the last five years has remained above it. The income now exceeds more than £1,500,000, say seven million dollars, though that is partly due to the raising of the contribution in order to meet the increased cost of the maintenance of the hospitals.

Moreover it must be remembered that a large proportion of the contributors are drawn from that section of the community which provides the majority of the supporters of the present Government. The problem accordingly was not whether the H.S.A. should continue but in what way the work of such a valuable organization could be best maintained.

Lord Moran, the President of the Royal College of Physicians, gave the answer in declaring that their anniversary celebration marked the betrothal of their organization with the State. In saying so he was supported by Sir Hugh Lett, the President of the British Medical Association and one of the Secretaries of

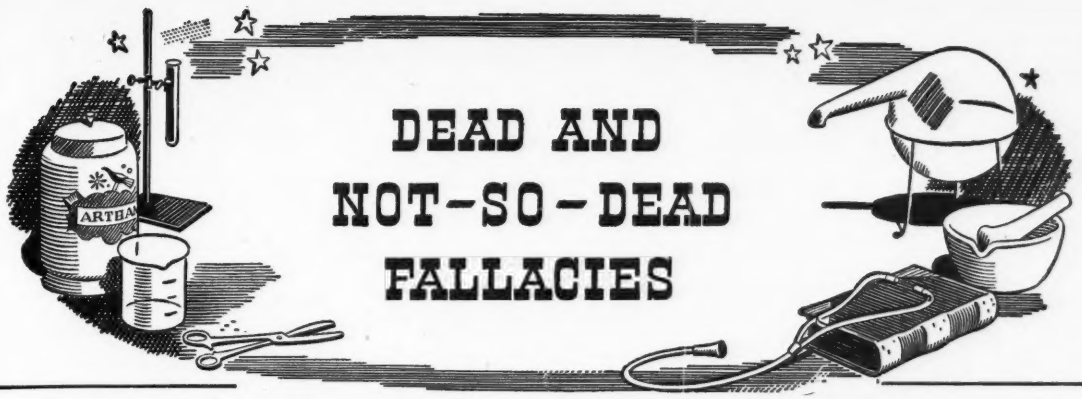
The "H.S.A" Assumes A New Role

King Edward's Hospital Fund, Mr. Fred Messer, a Labour M.P. who is chairman of Middlesex County Council, Sir Wilson Jamieson the Chief Medical Officer of the Ministry of Health speaking on behalf of the Minister, and other representatives of the hospital work. The common aim is to make that betrothal an effective union.

At a great popular gathering of more than two thousand group secretaries, graced by the presence of the Duchess of Gloucester, on the following night, the Attorney General, Sir Hartley Shawcross, gave the assurance on behalf of the Government that they desire to maintain the voluntary individual interest in the work of the hospitals. As the organization begins to take shape it becomes clear that the voluntary work will be necessary on a rather more intensive scale by perhaps a smaller number of people, though even that is not yet certain since the main governing bodies may require to enlist co-opted assistance.

The exact form in which the contributors to the H.S.A. will receive assistance cannot be determined until the Ministry's plans have advanced a further stage but the lines upon which the Executive Committee have been thinking were explained by their chairman, Mr. H. Lesser. Among the contemplated benefits is the provision of financial assistance when contributors or their dependants receive treatment in hospital. The new scheme will also include a standard maternity benefit in respect of every baby born to an H.S.A. contributor and grants towards after care treatment following illness.

Dr. Hill the Secretary of the British Medical Association and more widely known as the Radio Doctor made a suggestion which may well deserve the consideration of the Executive. He proposed that they should devote some of their income to the promotion of health education. This would be a suitable method of carrying out their original intention to save the hospitals. In these days owing to the financial responsibility being taken over by the State it is not the supply of funds which is their principal anxiety. The resources in man power and material at their disposal are not adequate to enable them to occupy the existing beds. That is their "headache" at the present time. Any activity which is likely to reduce the number of people seeking admission is the most helpful contribution which can be made to save the present situation.



DEAD AND NOT-SO-DEAD FALLACIES

To treat spider bites caused by venomous tarantulas in 15th Century Italy, village musicians were called upon to play lively music on the oboe, flute, and drum. The vigorous rhythm supposedly healed the victims—hence *the Tarantella!*

Many modern folk believe that it is not safe to leave food in the open can.

This is a fallacy, for as the U. S. Department of Agriculture states: "It is just as safe to keep canned food in the can it comes in — if the can is cool and covered — as it is to empty the food into another container."

CANCO **AMERICAN CAN COMPANY**
MONTREAL HAMILTON TORONTO VANCOUVER

Now available on request —

"THE CANNED FOOD REFERENCE MANUAL"

—a handy source of valuable dietary information. Please fill in and mail the attached coupon.

Canned Food is Grand Food

AMERICAN CAN COMPANY
Medical Arts Building, Hamilton, Ont.

Please send me the new Canadian edition of "THE CANNED FOOD REFERENCE MANUAL," which is free.

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Professional Title.....

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City.....Province.....

◄ Blue Cross News ►

Record Growth of Blue Cross

More than 28,000,000 persons in the United States and Canada are now covered by non-profit Blue Cross Plans for hospital service, according to an announcement by Richard M. Jones, Blue Cross Commission director of the American Hospital Association, at the end of the second-quarter enrolment period.

"Enrolment of 1,428,605 new members by the 88 Blue Cross Plans of the United States and Canada during April, May and June assumes more than usual significance," Director Jones points out, "considering that inflation has forced hospital costs upward and in many cases has increased the cost of Blue Cross coverage. The fact that nearly 1,500,000 persons joined Blue Cross this last quarter testifies to public recognition of need for protection against the financial hazards of unexpected illness."

The quarter's enrolment gain was surpassed in only two previous quarters in Blue Cross history. During the first half of 1947 enrolment figures exceeded 2,600,000. Total enrolment in Blue Cross as of July 1 was 28,330,166, which represented more than 20 per cent of the United States' population and more than 16 per cent of Canada's.

* * *

Purely Coincidental!

The Maritime Blue Cross plan received the following letter from a subscriber whose wife's contract was transferred to another plan in error for a subscriber of the same name:

"Your letter of the 17th instant received and I must admit that I am indeed surprised to note that my wife is now residing in Quebec province. Would you kindly supply me with her address as the lady with whom I am now residing resembles the person I married in 1940. However, I am not immune from making a mistake as in recent years my eyes have been failing me and it could be that I am living in sin.

After a great deal of consideration I feel it only fair on your part to supply me with the correct address of my wife in Quebec as no doubt the two of us would be very happy living together and apparently your association is the only one holding her present address. Any similarity to my wife and the person with whom I am living is purely coincidental and being a veteran of the last war I am again looking forward to living with my wife."

* * *

Enrolment Increases in Ontario

Ontario ranks fourth in enrolment growth among the 88 Blue Cross Plans for the month of April, May and June. During the first six months of this year enrolment averaged 216 new groups per month. The average last year for the same period was 194 groups per month. Latest reports reveal also that the gross enrolment average per month this year is 29,736 new participants, in comparison with an average of 27,846 new members for the first six months of 1946. Total enrolment in the Plan as of July stands at 892,841.

Deputy-Director Named for Plan in Ontario

The appointment of David W. Ogilvie of Toronto as Deputy-Director of the Blue Cross Plan for Hospital Care for Ontario has been announced by J. H. W. Bower, chairman of the Board of Administration of the Plan.

Commenting on the appointment, which is a new one, Mr. Bower pointed out that in view of the rapid growth of the Plan in the province and the daily increase in new subscribers the Board of Administration has approved the appointment of a deputy-director to assist in the overall administration of the Plan.

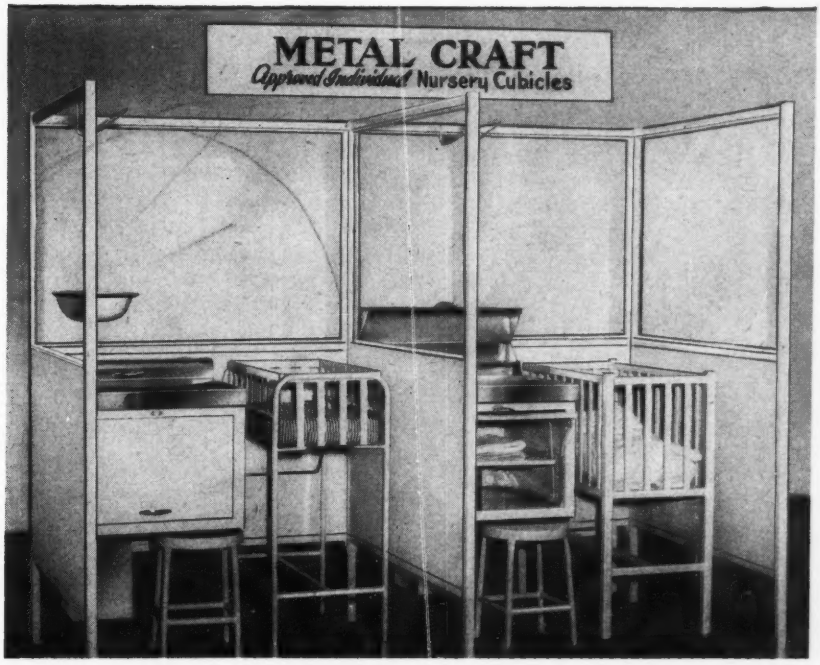
David W. Ogilvie.

Mr. N. H. Saunders, director for the provincial Plan, in discussing the new appointment, pointed out that Mr. Ogilvie had originally introduced the micro-filming of hospital case history records through his own organization and that the process has been of great benefit to many Canadian hospitals. The new deputy director, Mr. Saunders stated, brought to the Plan many years' experience in the administrative functions of hospital accounts and the adaptation of this knowledge in his new position will be invaluable to this non-profit hospital service organization.

Formerly president and general manager of Ogilvie & Parker, Limited, a firm which operated the Toronto Hospital Council Credit Bureau, Mr. Ogilvie is well known among Ontario hospital officials. He resigned in January from this position, which he had held for eight years, to form his own company, D. W. Ogilvie & Company, Limited, and operated the Hospital Credit Service until his recent appointment. Mr. Ogilvie was born and educated in Montreal and has lived in Toronto since 1936.

"I'll say they're good!"

There's something about a helpless infant that seems to call for the very best in care and attention. That's why Metal Craft Nursery Cubicles were designed with baby's comfort in mind as well as practical utility for the nurses.



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Here and There

By "THE EDITOR"

A Visit to Lower Quebec

FOR one all-too-fleeting fortnight this summer it was the privilege of the Editor and his wife to wander up and down the hilly roads north of the lower St. Lawrence between Quebec and Murray Bay. An earlier visit to this mountainous area had made us long to return to the romantic and historic region which provides a wealth of beauty unequalled anywhere else in Eastern Canada. The north shore between Quebec and the Saguenay gives one the fertile green valleys of Nova Scotia and New Brunswick; the blue mountains at sundown over silver-streaked waters of British Columbia; the haying activity of P.E.I.; the steep hills of Cape Breton and Gaspé — only much more so; the tides and salt water bathing of either coast; and of particular charm, the picturesque and colourful homes and barns of the habitant, found only in this fine old province. Everywhere is colour — and cleanliness. No wonder it is a painter's paradise!

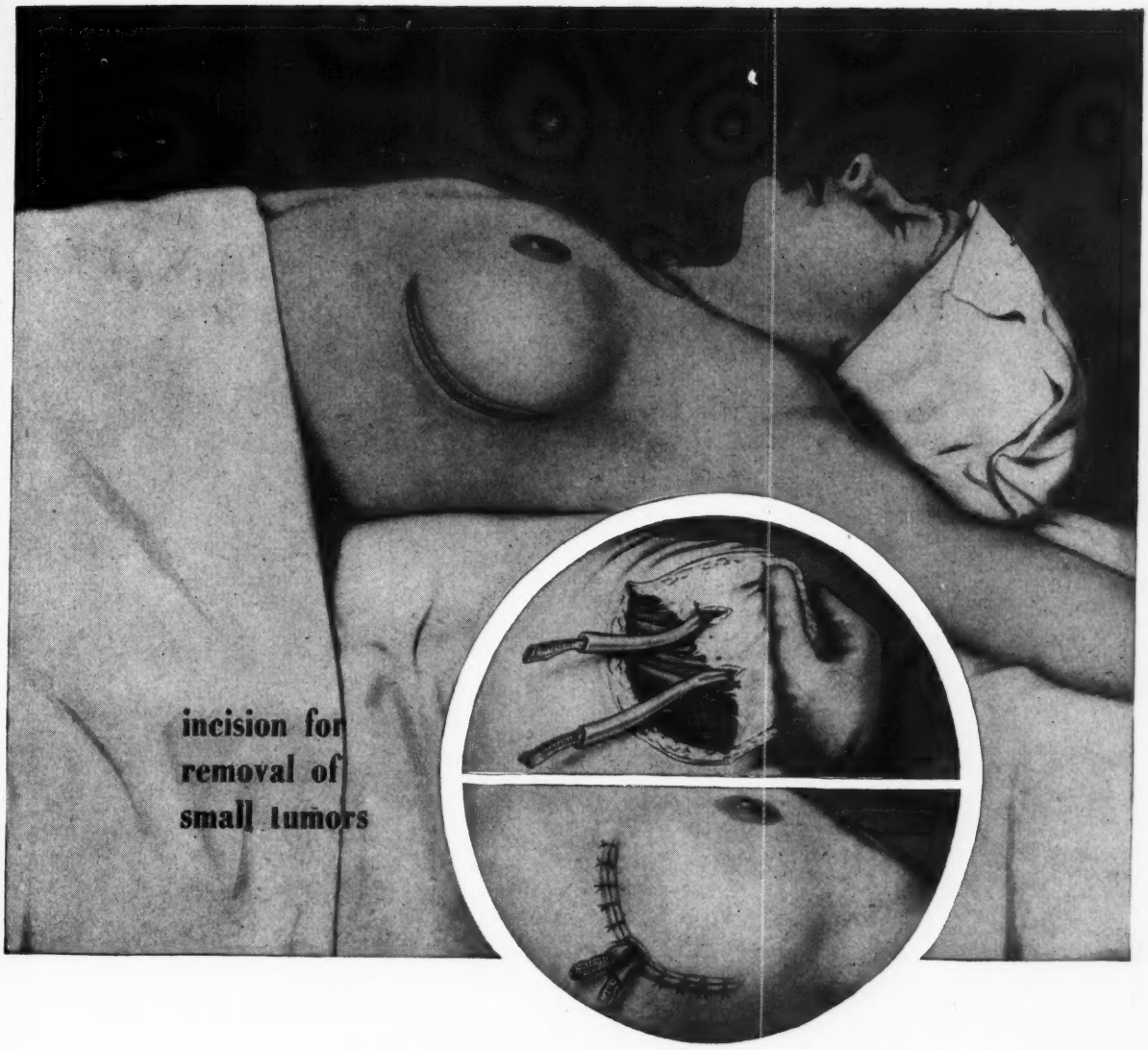
We made our headquarters at a straggling little village, St. Joseph de la Rive, which for a couple of centuries has had to keep to a straight and narrow path because of the towering cliff rising some 1,100 feet behind it and the lapping tide at its feet. During an earthquake back in 1663 there was a great landslide at this point; this gave the village its original name of Les Eboulements, but the name has been applied in more recent years to the village above it on the river highway. Few outsiders take even this road; most travellers to Murray Bay going by a route further inland. Those who do take the river road from Baie-St-Paul seldom venture down the steep "low gear" incline with its hairpin curves leading to the river far below.

From this base, if one's car can make the hill, it is only a few miles back to old Baie-St-Paul, made famous by Gagnon and other well-known artists of Charlevoix County, or down the river to St-Irénée-les-Bains and La Malbaie. Every hilltop on the road opens new panoramas or reveals little villages with the small, brightly coloured houses clustered like chicks about the parish church with its gleaming steeple. Back of Baie-St-Paul is attractive St-Urbain, much painted and called the "Christmas Card Village". On the way up the river valley one passes the farmhouse of the famous Bouchard family, noted for their wood carvings; of almost as great interest as their fine wood sculpture is their ingenuity in adapting a swift mountain stream to many uses, including that of washing clothes in a clever piece of outdoor wooden mechanism. Further east is St. Hilarion, best seen from a neighbouring hilltop. Off shore from St. Joseph de la Rive lies L'Ile aux Coudres, the home of some of the best homespun, and noted historically as the place where Jacques Cartier landed in 1535 to offer the first mass in New France. And always freighters and liners passing, now up, now down.

What if our host and his charming wife knew no English? N'importe! Their hospitality was unbounded and our efforts to speak French, which we practised on every possible occasion, caused much merriment. In fact our good intentions in attempting to converse as much as possible in French (a primary reason for taking the trip) were largely nullified by the courtesy of the French-speaking guests who insisted on conversing with us in English! Their obvious desire to become better acquainted with their English-speaking compatriots and to show them every courtesy augurs well for the future, indeed.

This courtesy was so noticeable in the rural areas. Stop the car to photograph an outdoor oven and the farmer's wife hurries over with some loaves of bread, to add the realistic touch; stop again to photograph a half-loaded hayrack against a backdrop of blue mountains and the farmer holds up proceedings until two of the small fry can be lifted to the horse's back to improve the picture. On Monday morning I selected a quaint old residence, which I knew to house a large brood of children, for a humorous painting of a house surrounded by the family wash and which would be entitled "Monday in Quebec". Getting there before the washing was put out, I painted away for an hour or two, waiting for the laundry to appear — which it did not, despite the warm sunshine. Finally I realized from the steady flow of children rushing back and forth reporting my progress to their mother that she must be deliberately waiting until I would be through so as not to spoil my picture! Feeling very guilty I hastily packed up and painted in the gaily flying laundry at a later date.

The sheer beauty of old French buildings is fascinating to one who deplores the ugly houses so universal in other parts of the country. The lines are so exquisite, and the proportions so perfect, even in many of the poorer farm houses. Even some of the small barns have well-designed mansard roofs. Unfortunately, most of the newer houses, even in the little towns mentioned, show the decadent influences of other styles — or lack of any style. We sincerely hope that the people of this province will never let their architecture degenerate to the merely utilitarian, as it has elsewhere.



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Annual Review of Hospital Statistics

THE *Annual Report of Hospitals in Canada* for the year 1945, which is now available at Ottawa, was prepared under the supervision of James C. Brady, Chief of the Institutional Branch, Dominion Bureau of Statistics, with J. H. Melanson in charge of the compilation and tabulation of data. As in other years the report deals with public hospitals as defined under the various provincial hospital acts, private hospitals and Dominion hospitals. While 600 are known to be operating, 13 hospitals did not submit the necessary data; hence this presentation of hospital statistics is based upon information supplied by 587 institutions.

The 587 hospitals which reported had a capacity of 51,670 beds and cribs, and 7,654 bassinets for newborn. General public hospitals had 45,022 or 87.1 per cent of the total number of beds and cribs, and 6,933 or 90.5 per cent of the bassinets.

Beds Per Thousand of Population

Based on the total population of Canada, the number of beds and cribs per thousand of the general population, by provinces, was:

Prince Edward Island	2.8
Nova Scotia	4.1
New Brunswick	3.4
Quebec	3.8
Ontario	3.9
Manitoba	4.7
Saskatchewan	4.6
Alberta	6.1
British Columbia	5.5
Yukon and Northwest Territories	4.6
CANADA	4.2

Personnel

One hundred and twenty-four public hospitals employed 372 full-time physicians and 124 institutions employed 324 part-time doctors, making a total of 696 doctors on salary. There were 888 interns employed in 101 hospitals. There were 267 hospitals with organized medical staffs and these reported 8,759 staff doctors, an increase of 283 over the previous year. The remaining 320 hospitals which did not have organized staffs reported a total of 1,347 doctors who attended patients during the year.

The number of graduate nurses on hospital staffs was 9,202, an increase of 279 or 3.1 per cent over the preceding year. There were 164 hospitals with approved schools of nursing, 34 of which had university affiliation. Students graduated during the year numbered 3,780. While the number of probationers was 54 less than in 1944, the total number of student nurses showed an increase of 289.

Total personnel of all reporting hospitals was 49,166, an increase of 1,864 or 3.9 per cent over the year 1944.

Admissions and Discharges

The number of adults and children admitted during the year was 1,143,554, which, together with 171,397 live births makes a total of 1,314,951 admissions in 1945. The following table shows the number per thousand of the population of Canada who were admitted to hospitals during the year (not including births):

Prince Edward Island	83
Nova Scotia	94
New Brunswick	86
Quebec	71
Ontario	94
Manitoba	110
Saskatchewan	121
Alberta	144
British Columbia	126
Yukon and N.W.T.	214
CANADA	94

Of the total number of admissions and births in hospitals, 1,234,888 or 93.9 per cent were admitted to general hospitals.

The number of patients under care in public hospitals for acute diseases during the year 1945 totalled 1,351,855.

Separations (discharges and deaths) during the year numbered 1,312,259 or 97.1 per cent of the total under care. Those discharged alive made up 96.9 per cent of the total.

The total patient days during the year was 15,706,159, giving an average stay of 11.6 days for all patients. There were 175,595 births in public hospitals in Canada during the year. These added to the number born in private hospitals comprised 60.9 per cent of all births in Canada.

Tuberculosis and Contagious Disease Units

Twenty-six hospitals reported upon tuberculosis units. These had a total capacity of 1,588 beds, 85.7 per cent of which were occupied during the year. There were 3,372 patients under care in these units during the year with an average stay of 147.4 days per patient.

Eleven hospitals reported contagious disease units which provided a total of 406 beds for this type of patient. The number receiving care during the year was 2,015, with an average stay of 19.3 days.

Finance

Detailed figures show that salaries and wages made up the largest single item of expenditure, comprising 46.6 per cent of the total. Supplies, the next largest item, accounted for 35.4 per cent.

Of the $74,059,491 expended for maintenance, $69,522,750 was for in-patients. On this basis, the cost per patient-day for all hospitals reporting was $4.45 (in 1945).

Hospitals for Incurables

Reports were received from 17 hospitals for incurables. These had a total bed capacity of 3,295 and in all 4,306 patients were given care during the year. The percentage of beds occupied was 88.6 and the average stay of patients was 246.5 days.

Private Hospitals

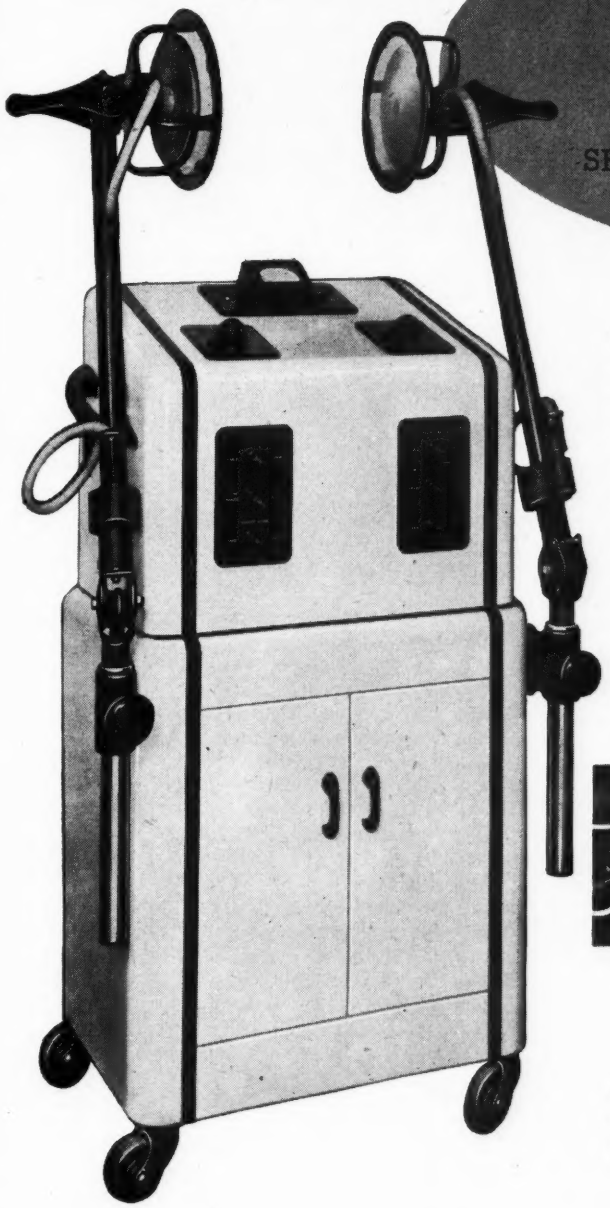
The number of private hospitals reporting in 1945 was 234 with a total bed capacity of 3,380 beds and cribs and 733 bassinets. Average occupancy of the beds and cribs was 66.9 per cent for the year.

Of these 234 hospitals, 57 had x-ray facilities, 33 had clinical laboratories, 26 had physiotherapy departments and 26 received out-

(Concluded on page 102)

SW 227

SHORT-WAVE DIATHERMY



The LF-SW227, a frequency controlled, short-wave unit, operates at 27.32 megacycles, one of the frequencies allocated by the Department of Transport for diathermy use. Thus the SW-227 user need have no concern with interference with communications.

The SW-227 is a worthy successor to previous LF models, and makes every known method of short-wave diathermy available to the user. He enjoys the advantages of the two most convenient, flexible, generally useful types of applicators – The Hinged Treatment Drum and Air-Spaced Plates – in addition to the conventional method of treatment, such as condenser pads, inductance cable and orificial electrodes.

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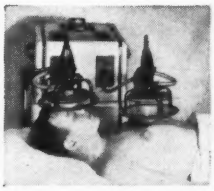

The Spaced Plates require only a few seconds to position.

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Ontario Hospital (Hamilton) Holstein creates World Record for Butter Fat.

A New Queen is Crowned

A NEW world queen has been crowned, but the glittering aureole was awarded, not for sheer feminine beauty and "oomph" but for the shattering of a world record — the production of 1,139 lbs. of butterfat on 2X — the highest fat total ever recorded by a cow of any breed and any age in the world!

The illustrious queen is O.H.H. Abbekerk Darkness 510547, a four-year-old Holstein on the 550-acre farm of the Ontario Hospital at Hamilton, Ontario. Starting her record at the age of four years 64 days, the world champion produced 1,139 lbs. fat from 25,711 lbs. of 4.43 per cent milk, to surpass all 2X records. Just a year ago Abbekerk Darkness was the Canadian champion junior 3-year-old, 305-day fat producer on 4X with 17,762 lbs. of milk, 4.33 per cent, 769 lbs. fat. That record was started at the age of three years 46 days; she was on 2X milking for the first 203 days, then 4X for 62 days and 3X for the last 40 days. She was also a superior producer in her first lactation. Dropping her first calf at two years 21 days, she made a 2X record of 16,043 lbs. milk, 3.61 per cent, 579 lbs. fat in 305 days, which is second high for milk and fourth for fat in that class in Canada. Continuing to 365 days this record was increased to 18,629 lbs. milk, 3.69 per cent, 688 lbs. fat, which was fourth for fat and fifth for milk in class when made. This gives Abbekerk Darkness the remarkable total of 62,102 lbs. milk, 4.18 per cent, 2,596 lbs. fat. It is believed that this is the highest fat total ever made in Canada in three heifer lactations.

The Men Behind

Among the men behind the champion, or champions, is Lloyd O. Teeple, the "Farmer" of the Hamilton institution, who is responsible for the 550-acre farm and its varied livestock. The hospital requires over a ton of milk a day and this is supplied by some 70 cows from a herd totalling around 120 head. Correspondingly large numbers of pigs and chickens are kept, yet the multiplicity of his duties does not prevent Lloyd from keeping close supervision over the feeding and care of the test cows. He is well supported by the men up the ladder in his organization — Steward R. F. Haney, Superintendent, Dr. J. N. Senn, and the Minister of Health himself, Hon. Russell T. Kelley.

Never Dry in Three Years

Most interesting feature about the champion is that she has never been dry in over three years of production. This practice of continual milking has been carried out with most of the Hamilton herd and seems to have relieved much of the udder trouble formerly encountered. Those familiar with the herd will remember that it was "loaded" a few years ago with positive and mastitis-riúden cows collected from all the hospital herds. Since then extensive experiments in the control of Bangs' Disease and mastitis have been carried out in the herd with astonishingly good results.

Continual milking, however, has not saved the udder of the champion who was never blessed with particularly good attachment. Though work-

(Concluded on page 102)

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GUMPERT

has EVERYTHING

Milestones in Nutrition

(Concluded from page 46)

they grew from the ends and not the middle. Belcher discovered that it was possible to dye new bone with madder and so make further study of it. The final work done in this field was by Papillon who attempted to make animals grow their bones out of magnesium and aluminum. He discovered that animals had convulsions when their diet was deficient in magnesium, but they remained normal if fed magnesium sulphate.

The Nineteenth Century

Two outstanding figures of the early 19th century were Cutbush and Graham. Cutbush described a method of drying yeast which made it available for baking fresh bread on board naval vessels. He advocated that fresh bread be introduced gradually to the naval diet so that the old sailors would not object to it and refuse to eat it. He also advocated that spruce beer be used as an antiscorbutic and suggested that more vegetables be used on board the vessels. It was at this time that dried vegetables were first introduced. Another naval surgeon suggested that more care be taken in the preparation and service of the men's meals, and he proposed that the navy stock cheap eating utensils so that the men would not use their large duty knives which were frequently covered with rope tar. It is also interesting to note that about this time, 1861, the first ice machine was in use on board a hospital ship.

Graham, on the other hand, was interested chiefly in the civilian population and attempted to convert them to the use of a vegetable diet. He also stressed the importance of fresh air and bathing. His other major project was an attack on the bakers in an attempt to improve the quality and value of bread. Graham was so firmly convinced that freshly ground flour was important that he advocated that every family have its own mill in the home. However, he was against the use of fresh bread and insisted that it mature for 24 hours before use. Recent investigations on board a navy vessel during World War II failed to show any basis for this and no bad results were found from the use of strictly fresh bread.

It is interesting to note that almost 100 years ago Boussingault ran chemical balance diets in calcium, using animals in his experiments. He also ran the first nitrogen balance tests on animals, but his tests failed because he lost nitrogen from his samples. He discovered that a certain race of people in South America who used iodized salt were free of goitre. He advocated the use of iodized salt and suggested that the level must be kept low to avoid the toxicity of the iodine.

Dietetics As a Profession

Dietitians as well as nurses honour Florence Nightingale as the founder of their profession. It was through her efforts that the first diet kitchen was set up at Scutari in 1855. She did manage to obtain punctual, well prepared meals for the soldiers and to obtain extra nourishment for those who needed it. However, she was never able to get the meat separated from the bones when it was cooked, and it was the soldier's misfortune if his daily portion happened to be all bones.

Alexis Soyer, a famour chef, offered to serve gratuitiously as manager and superintendent at Barracks Hospital in Scutari. His plans were as intelligent and modern as any today and were quite revolutionary. He proposed: (1) never to act without the sanction of the doctor-in-chief respecting diets; (2) to condemn and replace inferior provisions with better ones; (3) to have copies of recipes and methods printed and framed and placed on the wall, so that even soldiers, provided they could read, could do the work; (4) to submit every sample diet with a statement of the kind and quality of the ingredients of which the foods were made for the approval and opinion of the medical authorities.

Real dietetic training began, in 1870, in the form of a cooking school with Monsieur Pierre Blot as instructor. In 1887 the American Medical Association recognized the importance of dietetics and recommended that professors of dietetics be appointed for the medical schools. University training in this subject began in Wisconsin, in 1904.

It was in 1916 that the first group of dietitians organized as an association — the New York Dietetic Association under Elva A. George. The advent of war, bringing with it problems of food conservation, stimulated the growth of the Association. Dietitians were needed by the Armed Forces, the Red Cross and in civilian life. At a meeting of dietitians in Cleveland in 1917, Annie Laird, a Canadian and later Professor of Household Science at the University of Toronto, moved that a national association be organized. Thus the American Dietetic Association had its beginning. With a charter membership of 58, it has grown to well over 8,000 members. Its younger sister, the Canadian Dietetic Association, was organized in 1935 and now has a membership of over 600. The needs and demands of a changing world have expanded the possibilities of the profession beyond the dreams of the early pioneers.

Bibliography:

Seven Centuries of Scientific Nutrition — C. M. McCay, Journal of The American Dietetic Association, October, 1939.

Four Pioneers of Science of Nutrition — C. M. McCay, Journal of The American Dietetic Association, May, 1947.

A New Profession Is Born — M. P. Huddleson, Journal of The American Dietetic Association, July, 1947.

Food Service in Institutions — West and Wood, Chapter 1.

Displaced Persons to Help in Hospitals

Announcement has been made that, among the 10,000 displaced persons allowed entry to Canada, every effort is being put forth to obtain domestic workers. The first chosen for migration will be directed to hospitals and other institutions where serious staff shortages exist. An attempt will be made to place these people suitably, and they will be encouraged to accept one-year agreements with their employers with the proviso that a transfer to another institution may be arranged if desired.

Only after the needs of hospitals and institutions are met will the harassed housewife have an opportunity to get help. While the hospitals will train their employees, other organizations are co-operating in an endeavour to supply teachers to meet the language and psychological problems of the new arrivals.

A Favourite with Good Cooks!

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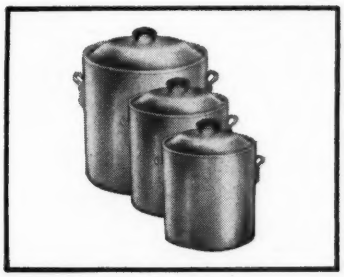
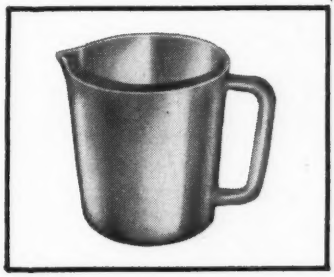
Chefs in today's hotels, hospitals and large institutions preside over all-aluminum kitchens. They prefer aluminum utensils that not only cook efficiently, but also stand up under hard usage. BEACON Permanent Mould heavy cast aluminum utensils are extra strong, retain heat, clean easily and their silver-like satin finish will not rust or corrode.



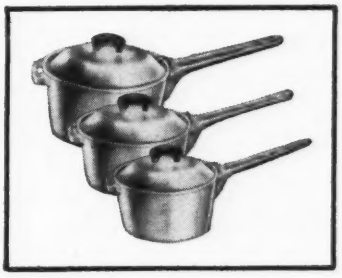
STOCK POTS

BEACON Stock Pots have close-fitting covers and sturdy handles. Made in 8, 6 and 4 gallon sizes, with or without spigots.



WATER PITCHERS

BEACON Water Pitchers are made in one quart size — suitable for general utility and bedside. Two finishes — polished and stain-resisting alumilite.



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The BEACON Sauce Pans illustrated, are made in 5, 8 and 12 quart sizes. They heat fast — cook efficiently. The handles are sturdy and the covers close-fitting.

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Maritime Conference, C.H.A.,

Celebrates

Silver Jubilee

TWENTY-FIVE years of service and progress was celebrated at this year's convention of the Maritime Conference held at Campbellton, N.B., August 19-20. When this branch of the Catholic Hospital Association was organized in 1922, there were 11 Catholic hospitals in the Maritime provinces with a total bed capacity of 541. Today there are 20 hospitals with a total capacity of 2,513 beds.

The oldest of these hospitals is the Halifax Infirmary which opened its doors to suffering humanity in 1867. In the following year the Sisters of the Hotel Dieu of Tracadie, N.B., opened the Lazaretto. Then came:

Hotel Dieu of St. Joseph, Chatham, N.B.	1869
Hotel Dieu of St. Joseph, St. Basile, N.B.	1873
Charlottetown Hospital, P.E.I.	1879
Hotel Dieu of St. Joseph, Campbellton, N.B.	1890
St. Joseph's Hospital, Glace Bay, N.S.	1902
St. Martha's Hospital, Antigonish, N.S.	1906
Hamilton Memorial Hospital, North Sydney, N.S.	1908
St. Joseph's Hospital, Saint John, N.B.	1913
St. Rita's Hospital, Sydney, N.S.	1920
Hotel Dieu of St. Joseph, Tracadie, N.B.	1922

Since the organization of the Association seven general hospitals have been opened with a total capacity of 222 beds. These are:

Hotel Dieu of the Assumption, Moncton, N.B.	1922
St. Mary's Hospital, Inverness, N.S.	1925
Sacred Heart Hospital, Cheticamp, N.S.	1931
Hotel Dieu of St. Joseph, Bathhurst, N.B.	1942
Western Hospital, Alberton, P.E.I.	1945
Hotel Dieu of St. Joseph, Dalhousie, N.B.	1947
Hotel Dieu of St. Joseph, St. Quentin, N.B.	1947

In 1932 the Sisters of the Hotel Dieu of Tracadie opened the first sanatorium under Catholic auspices in the Maritimes at Vallée Lourdes, near Bathurst, N.B. In recent years St. Martha's at Antigonish, St. Joseph's, Glace Bay, and St. Mary's, Inverness, have added annexes for tuberculosis patients and, in 1946, the Sisters of the Hotel Dieu of St. Basile opened a large new sanatorium.

During the twenty-five year period (1922-1947) 493,334 patients received care in the 18 general hospitals and 3,449 in sanatoria. Births numbered 57,473.

In 1922 there were eight schools of nursing with 107 students enrolled. Today there are eleven schools with 649 students. In the past twenty-five years, 2,158 nurses have been graduated, 141 of whom were religious.

In the same period 39 religious were registered as x-ray technicians, 26 as laboratory technicians, 16 as record librarians, 21 as pharmacists, one as a certified clerk in pharmacy, eight as dietitians, and two in social work. In addition, 49 religious graduated in either arts or science and three received Master's degrees. It is interesting to note also that two hold certificates in hospital administration, three are members and three are Fellows of the American College of Hospital Administrators.

On January 1st, 1947, the combined personnels numbered 1,800, of which 353 were religious and 1,447 were lay persons.

The total operating expenses for these hospitals during the twenty-five years amounted to $20,189,817.55.

The Jubilee meeting was opened with Pontificial High Mass at which His Excellency, Bishop C. A. LeBlanc officiated and the sermon was read by Rev. J. B. Nearing, Spiritual Director of the M.C.C.H.A. Then followed the splendid address by the president, Mother Ste. Theresa of Campbellton. In the course of the two-day program the history of the Association and its member hospitals was reviewed and relevant hospital problems were discussed. Wednesday morning was given over to the presentation of papers dealing with nursing and nurse education. Among those who took active part in the program were: Rev. Father H. J. Bertrand, S.J., President of the Catholic Hospital Council of Canada; Rev. Mother Audet, Sorel; Dr. J. A. MacMillan, Charlottetown; Sister Mary of Calvary, Antigonish; and Sister Catherine Gerard, Halifax. The President, Mother Theresa, and the Secretary, Sister Kerr, now of Perth, as well as those who assisted them, must be congratulated upon the organization and smooth functioning of a highly valuable and uplifting program on this memorable occasion—the 25th anniversary of the M.C.C.H.A.

Majority of Nursing Sisters Remain in Chosen Profession

A survey, undertaken by the Department of Veterans' Affairs, reveals that about 44.5 per cent of all nursing sisters formerly serving in the armed forces are still employed as nurses, according to a recent announcement by Veterans' Minister Ian Mackenzie.

Based on replies from 1,571 of the 4,400 who served in the armed forces, the survey showed that 27.9 per cent are busy with home duties, 17.9 per cent are taking D.V.A. rehabilitation training, 3 per cent are unemployed, 2.4 per cent are in poor health, 2.2 per cent awaiting suitable employment and 2.1 per cent are employed in an occupation other than nursing.

At the time of the survey there were 282 enrolled in D.V.A. rehabilitation courses and of this number, 245 were studying subjects in the field of nursing and undoubtedly will return to their profession on completion of training, the Minister said.

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Provincial Notes

British Columbia

ALERT BAY. The board of directors of St. George's Hospital here has purchased the former RCAF hospital at Port Hardy. The 50-bed building is to be cut up into sections and floated forty miles down Johnston Straits to its new site. The present hospital is to be renovated to provide staff accommodation for the new hospital.

* * * *

MISSION. Contract has been awarded and construction is to commence immediately on a $50,000 addition to the Memorial Hospital here. Plans by John H. Harvey, Vancouver, show that the extension will conform to the present frame and brick exterior building.

* * * *

VANCOUVER. Tenders are called for the proposed conversion of the former administration building at Shaughnessy Hospital into a surgical operating and therapy department at an estimated cost of $200,000. The new operating department will occupy the entire top floor and one of the operating rooms will have a viewing gallery with a plate glass dome, fitted with microphones to enable spectators to follow proceedings below. It is believed to be the first viewing gallery of this type in any Canadian hospital.

* * * *

VANCOUVER. Vancouver East Lions Club have donated $4,000 to the Children's Hospital to start a travelling clinic in this province. Previously this service organization have donated $25,000 to the hospital, $10,000 to the Victoria Solarium, $5,000 to the Vancouver Preventorium, and $1,000 to St. Christopher's Home, North Vancouver.

* * * *

VICTORIA. Dr. H. M. Edmison has been appointed assistant radiologist at the Royal Jubilee Hospital, and commenced his new duties this month. A graduate of the Manitoba University, Dr. Edmison was associate radiologist at St. Boniface and Winnipeg Children's Hospitals. He held a teaching appointment at the University of Manitoba Medical College as demonstrator in radiology and is a certified specialist in diagnostic and therapeutic radiology. During overseas' service he served as radiologist of No. 5 Canadian General Hospital, and was in full charge of x-ray department of the Canadian Red Cross Hospital at Taplow, England.

Alberta

CALGARY. Tenders are being called for the new four-storey, 150-bed Junior Red Cross Crippled Children's hospital here, and construction is expected to commence in the spring. When completed, it will ensure treatment for all crippled children in the province. Features of the new hospital will include: an operating room, physio-therapy ward, swimming tank, gymnasium, poliomyelitis ward, schoolroom, nurses' residence, kitchens and laundry.

* * * *

EDMONTON. Contract has been awarded and work will start at once on the construction of a $65,000 temporary wing to the Edmonton General Hospital. Pending greater availability of building materials, the new temporary wing will help relieve the congestion by another sixty-five beds.

* * * *

INNISFREE. A Municipal Hospital District has been established by the Minister of Health and a Provisional Hospital Board appointed to prepare a plan for the building and operating of a hospital for the district. Subject to the final approval by the Minister of Health and subsequent to the ratepayers' approval it is proposed to acquire a suitable site on which a 20-bed hospital will be constructed.

* * * *

RED DEER. Plans are under way by the Red Deer hospital board to enlarge the present hospital area, in order to improve the present hospital facilities and afford better service to the community. The new scheme if accepted by the respresentatives of the various districts, would be served by contract. It would include the addition of another sixty beds, new quarters for the nurses, and alterations to the present building at an estimated cost of $300,000. The present 53-bed building is now operating at capacity and during the past year had over 3,000 hospital days.

Saskatchewan

FOAM LAKE. An addition to the Union Hospital here is now under construction and will be known as the Dr. Somers' Memorial Wing. The first item of equipment received for the new wing is an X-4 incubator. Other new equipment is being made available through the Dr. Somers' Memorial Fund, a fund set aside to honour a pioneer doctor of this district and which will be spent in the purchase of equipment for the maternity and operating rooms in the new wing.

* * * *

KAMSACK. Residents of this union hospital area have approved the purchase of the King Edward Hospital for $22,500 and will build a new hospital here at an estimated cost of $170,000. The Kamsack union hospital district comprises parts of the rural municipalities of Sliding Hills, Calcar and St. Phillips, all of the rural municipality of Cote, the town of Kamsack and villages of Verigin and Togo.

* * * *

LEROY. Premier T. C. Douglas officially opened the Union Hospital here last month in a ceremony wit-

(Continued on page 64)

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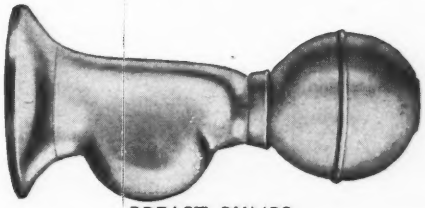

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TORONTO WINNIPEG CALGARY VANCOUVER

Provincial Notes

(Continued from page 62)

nessed by more than 2,500 residents. The new hospital was developed from buildings transported from the Dafoe airport, and although it has not been completely staffed, at the time of the official opening the hospital had three adult patients and a new-born infant.

* * * *

SPIRITWOOD. More than 1,000 persons witnessed the official opening of the new $85,000 Union Hospital here by Premier T. C. Douglas. The new health centre, supported by the community, the district, and by the provincial government, is one of the first of its kind in the province. Declaring that his government believed in "helping those who help themselves", Premier Douglas said he hoped in the near future to see the province "dotted" with similar institutions, providing good medical care and hospitalization. Three years ago, it was recalled, there was no doctor in the immediate district and no hospital facilities. The Board of Trade, itself, undertook to sponsor a temporary hospital for the purpose of supplying services to the sick of the community and for two years carried the financial burden of operation.

Manitoba

WINNIPEG. Construction of the $1,000,000 Kirkfield Park convalescent home three miles west of Deer Lodge Hospital, commenced in May, 1946, has been halted, according to an announcement by Walter Woods, deputy minister for Veterans' affairs. Slightly more than $250,000 have been spent on the project. Suspension of the work may result in the project being entirely abandoned, officials said, due to the fact that there is no pressing need for beds at such an institution, where there are no emergency cases, and it is felt that the department is not justified in using labour and material which is more urgently needed for veterans' housing.

Ontario

AMHERTSBURG. The new Belleview Veterans' Home, near London, has opened to receive the first patients from Westminster Hospital. The Home, which was purchased by the government a few months ago, is situated in seven acres of land, mostly gardens, and commands a fine view over the lower Detroit River. G. A. Grieg, formerly of Westminster Hospital, has been named manager of the new hospital, which has undergone considerable renovation.

* * * *

APSLEY. Dedication ceremonies were held at the official opening of the Apsley Outpost Hospital which has been completely renovated and enlarged by the Ontario Division of the Red Cross Society. The Peterborough branch of the Society in cooperation with the Apsley branch was responsible for financing the cost of the 8-bed hospital.

* * * *

HAMILTON. City Council will ask the Ontario Municipal Board for permission to spend $2,551,000 for construction of a 181-bed addition to the General Hospital, and an additional $700,000 to furnish the structure. The proposed new active bed wing would consist of eight floors and a basement — comprising six patient floors with a total of 181 beds, an x-ray floor, another for x-ray treatments, and one floor of dining rooms — according to preliminary plans submitted to the Board of Control by MacDonnell and Lenz, architects.

* * * *

HUNTSVILLE. Plans have been approved and the contract awarded for the construction of a Red Cross Hospital here. Excavation will commence at once and the structure will follow closely the latest design in hospital architecture. It will be a one-storey building and the semi-circular design will include a central section, with two extended wings, stretching east and west.

* * * *

KINGSTON. The contract has been let for the construction of a new nurses' wing at Hotel Dieu Hospital at a cost of $300,000. The building will consist of a basement and two storeys and will be constructed so as to permit of additional storeys in the future.

* * * *

LONDON. Dr. Barclay McKone, of Peterborough, formerly on the medical staff of the Kingston DVA Hospital, has been apointed medical superintendent of the Western Counties Veterans' Lodge here. The only one of its kind in Canada, the London rehabilitation unit forms a link between the sanatorium and the home. Here veterans will have full opportunity to rehabilitate themselves while their health returns to normal. Dr. McKone is responsible for every phase of operation in the lodge, including occupational and vocational therapy, diet, management, rehabilitation and staff functions.

* * * *

ST. THOMAS. Miss H. Sterritt, who has been with the Ontario department of Public Health at Port Arthur during the summer months, will shortly commence her duties of laboratory technician for the Memorial Hospital in this city.

* * * *

TRENTON. Foundation walls of the Trenton Memorial Hospital are going up and good progress is being made following a short delay due to lack of materials. The first sod for the building was turned last fall at a public ceremony.

* * * *

TORONTO. The contract has been awarded for a $518,000 extension to the out-patients' building at Sunnybrook Hospital.

* * * *

WINCHESTER. The contract has been let at a price of $144,500 for the construction of a 32-bed hospital in accordance with plans and specifications prepared by Cecil Burgess of Ottawa, architect for the Winchester District Memorial Hospital board. The new institution will be of cottage type with basement and one storey. It will be about 200 feet

(Concluded on page 98)

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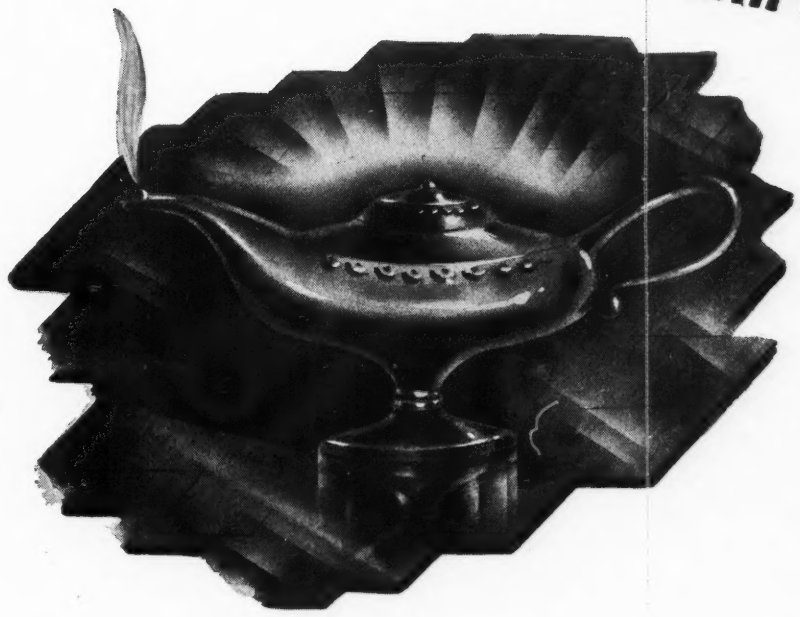

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Nursing Service

(Concluded from page 30)

problem in its effect upon the nursing service is that of the *radio*. Certainly the psychological factor of the patients' contentment cannot be ignored as a healing and curative factor; hence the radio problem is one of control because, if used injudiciously, it can interfere with the progress of recovery. The ordinary means, which suggests itself for such control, is that of reasonable regulations concerning hours and volume, and the number of patients in the room. These regulations, it is assumed, will be not only made but enforced. Recently, the use of the central radio with ear phones appears to have made progress in preventing the "nuisance" element of the radio.

The chief objective of nursing service is to give the best possible nursing care to the patients. Hence, it becomes the task of the nursing department to eliminate or control whatever interferes with the progress of the patient. Another source of trouble to good nursing service is that of *patients' visitors*. Dr. MacEachern classifies visitors as: "the near and dear relatives" (in which category he also considers clergymen) and the "casual visitor".[6] While every possible consideration should be shown the former, some element of control is essential in the case of the latter. The patient who is allowed a constant stream of visitors all day, or an overcrowded room during visiting hours, cannot reasonably be expected to derive the full benefit from his stay in the hospital. Not only does he, himself, suffer, but often the noisy talk and laughter coming from his room may be a source of annoyance and even of positive harm to other patients.

Such is the problem. It is evident that, during the acute stage of a patient's illness, only the near and dear relatives and clergymen should be permitted in the sick room. With tact and courtesy, others must be excluded. The period of convalescence is different. Then, regulated visits may well be permitted. The difficulty is in making regulations which are reasonable for patient, visitor and nursing staff. In considering this difficulty, three aspects of the problem present themselves as important:

1. A reasonable uniformity in casual-visitor-regulations in hospitals in a given area or location. This would do much to influence favourably the mental attitude and understanding of the public.

2. The tactful and intelligent explanation to the patient of his own need for curtailment of visitors. This is important since it is his liberty that is being curtailed.

3. Tactful and courteous publicity through co-operative press relations. Much of the inconvenience and harm resulting from visiting is the result of *well-intentioned*, though *unwisely expressed* interest. Newspapers, through well-designed articles published from time to time, would help the public to understand that, when their visits are discouraged by hospital authorities, it is in order to hasten the patients' recovery.

Three Other Factors

Three other factors contribute to the effectiveness of the nursing service. The first is *rotation of students*. This duty is the responsibility of the superintendent of nurses, and does much to make her office one of the least if not *the* least, enviable of all hospital positions. While it is true that the students render valuable service on the floors, the superintendent must keep in mind that she is obligated to furnish the students with a well-rounded experience in all the departments. Therefore, the education of the student may not be sacrificed to keeping the floors staffed. As far as it is possible, the student's clinical experience should be correlated with her classroom instruction, so that she may render safe, efficient, and intelligent nursing care. This may be achieved by a *ward teaching program* under the direction of qualified clinical instructors who plan their programs in co-ordination with head nurses and classroom teachers.

A second factor, is the *method of assignment* used on the wards. The *functional* method appoints one nurse for temperatures, one for medicines, et cetera, while the *case* method assigns four or five patients to one nurse who is responsible for the total nursing care. The latter method is preferred by many for the reasons that the nurse can know her patients better and can plan her work according to the treatments to be given them. Indirectly, it is helping the student to develop her own judgment and administrative ability.

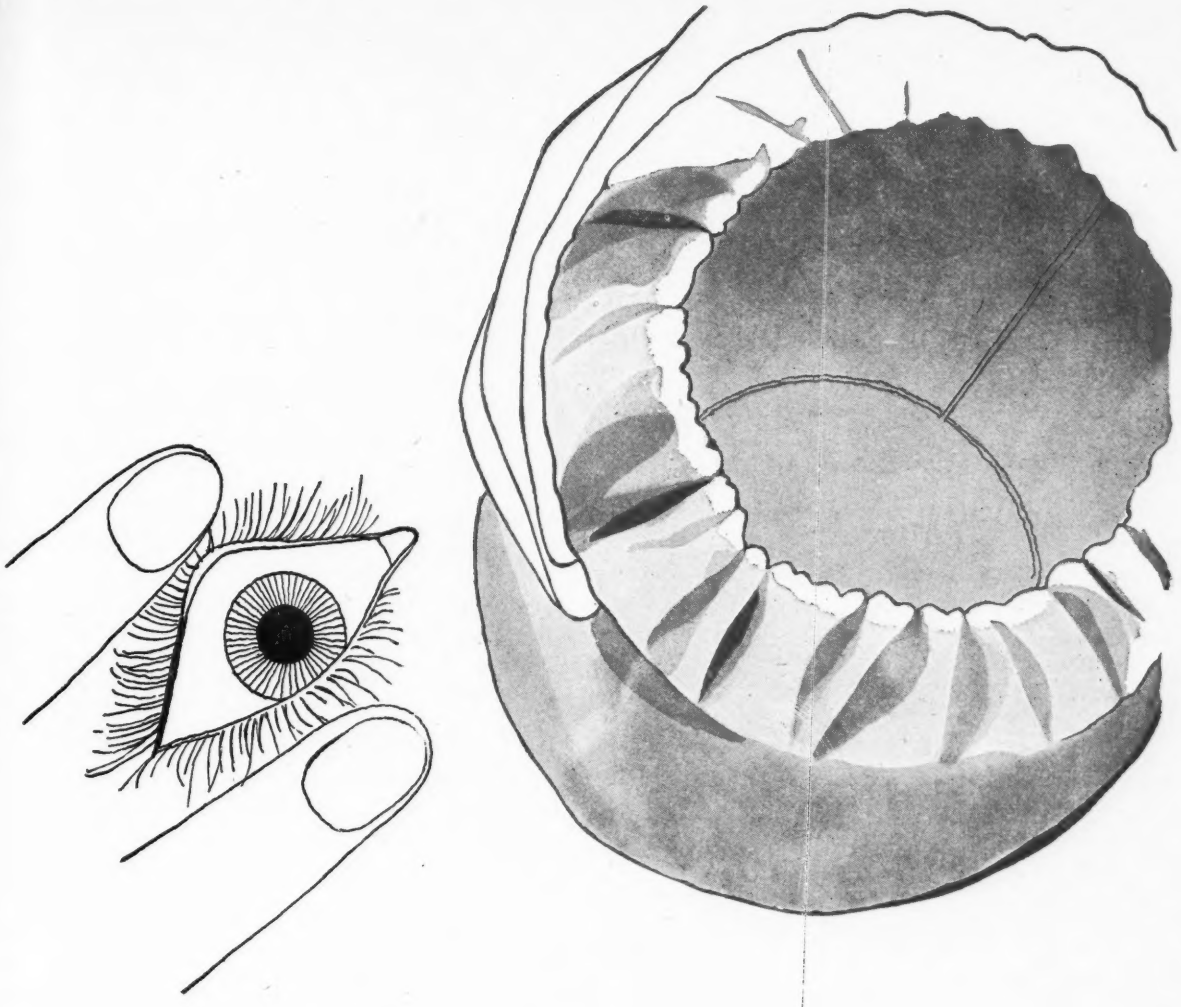
The third factor is that of *qualities of leadership* in head nurses. This cannot be too carefully considered in view of the ever-growing emphasis being placed on the individual. The personality of those with whom we work must be taken into account more today than in the past. It is the privilege and duty of the head nurse to guide, stimulate and encourage the young people over whom she is placed. A study of the temperament and character of each student under her direction will enable the head nurse to learn where her strengths and weaknesses lie, and so to point out to the student how she may make the best use of her natural qualities. In such an atmosphere of understanding and sympathy, the student will be able to make her best contribution to the nursing service. To quote John Buchan, "The task of leadership is not to *put* greatness *into* humanity, but to *elicit* it, for the *greatness* is already there."

Finally, when all has been said, whatever our efforts toward developing an effective organization and an efficient operation, it still remains true that both of these are dependent upon the generous co-operation of each individual in the organization, however great or humble his or her position may be. This thought is admirably summed up in a verse which appeared in one of our hospital journals a few years ago:[7]

"The works of life's time-piece are fashioned with skill,
Each part, a position of trust;
The tooth on the cog, or the pin in the wheel
Is God-planned to fit — and it must.
If you can't be a sunbeam effulgently grand,
Illuminating the world's noblest deeds,
You *can* lift up a candle, with love-trembling hands —
That's the candle that somebody needs.
The low-beaded task is Royal-breasted, you know,
(Not by worth or measure of gain),
For a KING, down in Galilee, long, long ago,
Used a carpenter's chisel and plane."

6. "Hospital Organization and Management", by M. T. MacEachern, Chapter IX.

7. "Hospitals", 1941.



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Fight Against Cancer

(Continued from page 27)

provement in certain cases and indeed there is considerable evidence that this will be the case. The extent to which such increased power can be utilized, however, will still be determined by the second law and this is inherent and fundamental. This does not at all mean that greatly improved methods may not come out of this newly acquired weapon. It only means that this has not yet been proved to be the case and that in the meantime exaggerated hopes based on false premises will do no good and possibly much harm.

In the field of chemistry there have been important advances of great interest to everyone interested in cancer. These include the demonstration of the similarity between the chemical structure of the molecules of sex hormones and of carcinogenic substances and the effects in actual therapy of sex hormones of the opposite sex, *e.g.*, the effects of the female sex hormone, oestradiol, in cancer of the prostate, and of the male hormone, testosterone, in cancer in female patients. The full significance of these facts has not yet been determined, nor whether they constitute a true "lead" or may merely be unrelated though interesting facts.

Thus, although great and substantial progress has been and is being made in the field of research, there is as yet no indication that a single specific cure, applicable to any and all forms of cancer, is in sight. This being the case, the sensible thing to do in the meantime is to fall back upon the statement made in an earlier paragraph — that progress could be made even if no such spectacular cure were ever discovered, merely by putting into effect the methods already known and in use, and doing this on an adequate scale.

Two Groups

All cancers may be divided roughly into two great groups. In the first are those in which the disease gives early and usually quite ample and adequate warning. In this group the diagnosis is relatively easy and should be made accurately at an early stage. This group includes:

(1) **Lesions which are open to inspection — cancer of the skin, lips, mouth, et cetera.**

(2) **Lesions which form palpable masses and can be felt, e.g., cancer of the breast.**

(3) **Lesions which cause abnormal bleeding, e.g., cancer of the uterus, of the bladder, rectum, et cetera.**

(4) **Lesions which obstruct the respiratory passages or cause progressive hoarseness.**

It is in this group of cases that progress and improvement can be brought about at once with proper organization.

The second group includes those cases which develop insidiously, usually in an internal organ, and give no indication of their presence at a stage where successful treatment can be undertaken. Any progress in this second group will of necessity be slow, and treatment by existing methods will continue to be unsatisfactory.

Cancer of the Skin

Cancer of the skin is probably the commonest form of cancer and is at present curable by appropriate treatment in approximately 95 per cent of cases. And yet the records show that 900 persons have died from cancer of the skin in Ontario in the past ten years. Much could be accomplished if more attention were paid to those lesions which should be recognized as pre-malignant and treated during this stage. At this time (while the lesion is still not malignant) many patients neglect to consult a doctor or decline to have anything done and, since there is no definite threat to life, many go untreated. A serious responsibility is assumed by everyone who undertakes the treatment of any malignant lesion, since here, to a greater extent than in almost any other disease, nature gives little or no help and the fate of the patient is usually determined by the success or failure of the first method of treatment adopted.

Cancer of the Lips and Mouth

In cancer of the lips and mouth, improvements in methods of treatment have increased the percentage of cures more than 50 per cent in the past ten years and this figure can be still further improved.

Cancer of Uterus and Breast

Cancer of the *uterus* provides an excellent illustration of what could be accomplished under ideal circumstances and also emphasizes the practical difficulty in overcoming ignorance, superstition, fear, and just plain indifference. In this form of the disease records show that 75-80 per cent of the early cases are being cured *now by means we already possess.* This surely is a high percentage, judged by any standards, when applied to a dangerous and potentially fatal disease. If 80 per cent of all cases were being cured it would be felt that the disease no longer constituted one of the great medical problems. But the difficulty is that a majority of the patients coming for treatments are already in an advanced stage when first seen by any doctor.

Someone has made a most excellent recommendation which is too idealistic to be adopted, but could be of inestimable value in the preservation of our health. Many mothers commence a diary when their first baby is born and make therein sentimental records of colour of hair, weight, first appearance of teeth and other "cute" characteristics. This

(Concluded on page 72)

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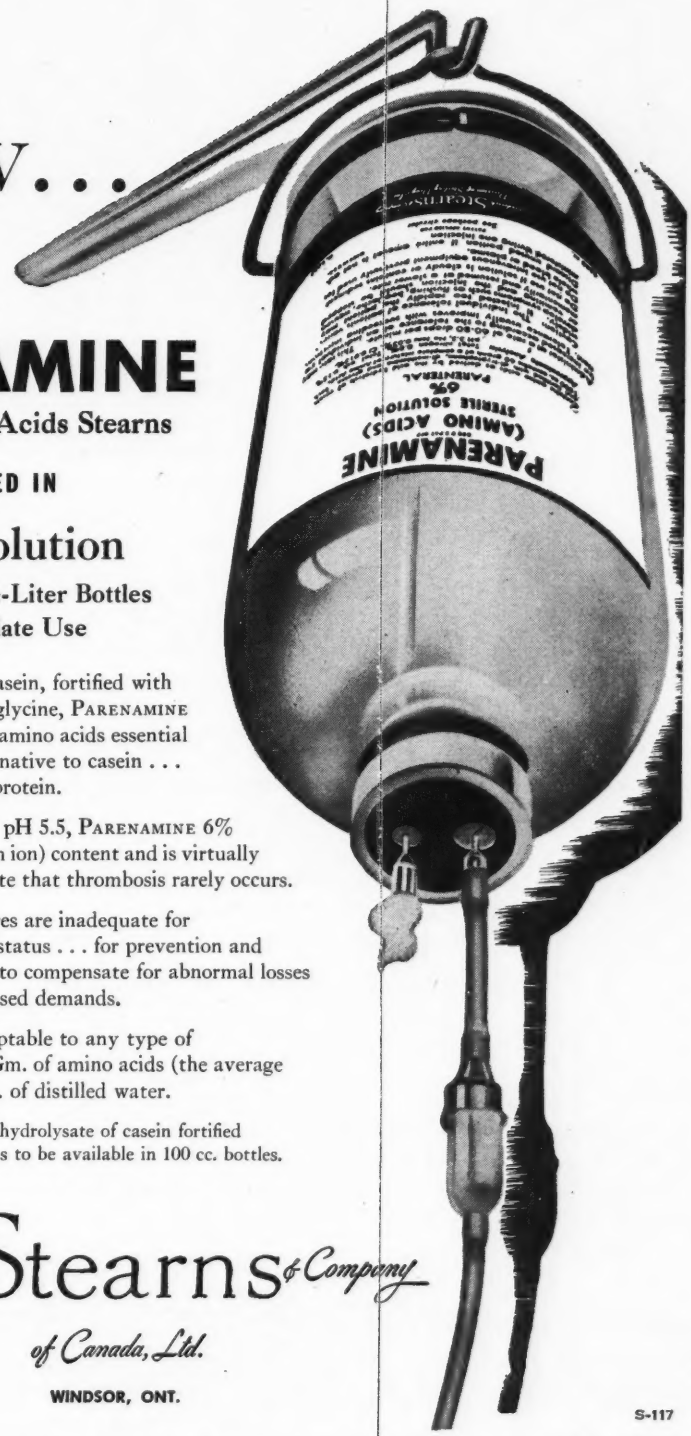

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Fight Against Cancer

(Concluded from page 68)

diary gradually dwindles, loses interest and is finally discontined. But suppose that instead of being regarded as a sentimental bit of foolishness it were continued throughout the life of the individual as a personal history of health, including a complete record of all illnesses, accidents, and admissions to hospital; and were made the occasion for an annual and, after middle life, a semi-annual complete physical examination, all the details of which were recorded in the diary. It is quite impossible to exaggerate the value of such a document. All manner of diseases now unsuspected or actually concealed would come to light and could be dealt with.[1]

Next to cancer of the uterus, cancer of the *breast* is the most important one in female patients. The scope of the problem is indicated by the fact that fifteen hundred women die every year in Canada from this disease, and it is estimated that there are five to six thousand cases in existence at all times. In ten years there has been a steady improvement in the results being obtained in treatment. Dr. Ivan Smith, in a recent article,[2] reports an improvement in Stage II cases amounting to over 100 per cent increase in five-year cures. This is another instance of a hopeful indication; the only difficulty being to apply it on a broad enough scale. In all attempts to do so the medical profession is confronted at almost every turn by fear on the part of patients.

Such fear should be interpreted by us as a vote of want of confidence on the part of the public as to our ability to deal with their particular problem and, unfortunately, this is nearly always due to the knowledge they have of some friend or relative who was unsuccessfully treated for some form of cancer. All the propaganda in the world cannot abolish this fear. It is my firm conviction that the only way in which it can ever be diminished and finally removed is by the development at strategic points of centres in which the results of treatment will be so good as to create confidence, in each community served by such a centre, that a diagnosis of cancer is not necessarily a death sentence, provided treatment is undertaken during the early and curable stage. The thing the patient should fear is not the disease but delay in having it treated. The motto on the letterhead of this Foundation is a quotation from the writing of Madame Curie, "Nothing in life is to be feared, it is only to be understood". Fear of cancer on the part of the patient can bring nothing but disaster, whereas knowledge of the nature of the disease and of the conditions which are absolutely essential to successful treatment could bring about almost revolutionary changes if adequately applied.

Ideal Program

To do this requires certain types of specialized organization which the Ontario Cancer Foundation is trying to develop, and also requires a complete program for the care of the cancer patient if he will make use of it.

The following points are believed to be essential to the success of any such program:

(1) **Registration of cancer cases in every community.**
(2) **Expert, early diagnosis.**
(3) **Consultation before any major procedure is undertaken, either surgery or radiotherapy.**
(4) **Complete investigation, including all known tests, clinical, bio-chemical, bio-physical.**
(5) **Facilities for dealing with all complications which may develop during surgical or radiological procedures.**
(6) **Follow-up care by the patient's family doctor and visiting nurse.**
(7) **Accurate follow-up for life of all cases so far as patients can be induced to co-operate.**
(8) **Finally, an impartial statistical evaluation of all methods of treatment by an expert staff of medical statisticians with control of procedures on this basis, and adjustment or correction from time to time, as may be indicated.**

If, as a result of the work done here, ignorance can be overcome, superstition broken down, and fear abolished, there is no doubt that much good will result throughout the whole area served. These evidences of progress in the education of the public, together with the constant effort to bring about improvement in methods and results, should be a great source of satisfaction to those responsible, who must always remember the good psychology expressed centuries ago in the *Talmud* and which applies so well today to all those working under our present circumstances:

"The day is short and the work is great. The reward also is great and the Master praises. It is not incumbent upon thee to complete the work, but thou must not therefore cease from it."

1. A similar suggestion has been incorporated in book form by Dr. J. C. Connell, entitled, "The Book of Life", Ryerson Press, Toronto.

2. The Ontario Medical Bulletin, February, 1947—Vol. 14.

Saskatchewan to Train Psychiatric Workers

The new mental health program for the province of Saskatchewan will affect both patients and staff in institutions for the mentally ill. According to a recent announcement by Premier T. C. Douglas, the old system of custodial care given by untrained or partially trained staffs will be largely replaced. Nearly all employees of the hospitals will be required to take a three-year training course which will qualify them as psychiatric workers capable of taking an active part in the treatment program. The newly trained staffs will work under close observation of psychiatrists. An effort will be made to recruit more and more competent people for this important service and others will be trained to work as instructors in schools for mentally retarded persons.

At the Weyburn hospital training school, Dr. F. Lester Bates has been appointed as director of education. He will be responsible for organizing a staff training course leading to a diploma in psychiatric nursing, and a post-graduate course in mental hygiene. He will also organize staff instruction in psychological subjects, recreational therapy and occupational therapy. The Weyburn training school cares for mentally retarded patients who can be trained to take a useful place in society and Dr. Bates will also be responsible for patient training.

At the Battleford hospital, Mr. Fred MacKinnon has been appointed supervisor of staff training. The program will be essentially the same as that conducted at the Weyburn hospital, and his duties will include the placement of patients in occupational and recreational therapy.

The Royal College of Physicians and Surgeons of Canada

STANDARDS OF APPROVAL OF HOSPITALS FOR ADVANCED GRADUATE TRAINING

The Committee on Approval of Hospitals for Advanced Graduate Training is now prepared to receive applications from Canadian Hospitals for approval as institutions in which training may be taken in fulfilment of the requirements for Fellowship in Medicine and Surgery, and the Medical and Surgical specialties; and for certification in those specialties which have been approved for certification by the Council of the College.

The Standards which will be required for approval of hospitals for Advanced Graduate Training are as follows:

1. The hospital must be suitably planned and have adequate facilities and equipment for the care of patients and the practice of medicine by scientific methods.
2. There must be indoor and outdoor services with a sufficient variety of clinical material and a sufficient number of patients in attendance to provide the graduate student with adequate opportunities for training and experience in the broad fields of medicine and surgery and/or the special branches of medicine and surgery for which the hospital seeks approval for training. These services shall be in charge of an organized Medical Staff.
3. Each division of the indoor and outdoor active Medical Staff shall be in charge of a Chief-of-service with the necessary number of staff assistants, each certificated as a specialist. It is desirable that the Chiefs-of-service and their assistants be Fellows of the Royal College.
4. The following special departments and services must be maintained:—
   (a) Adequate laboratory facilities and personnel under competent medical supervision.
   (b) A department of radiology properly equipped and under competent medical supervision.
   (c) A department of physical therapy properly equipped and under competent medical supervision.
   (d) Efficient dental, nursing and dietary services. Occupational therapy and social service departments are highly desirable.
5. Accurate and complete medical records of all patients treated by the services of the hospital must be kept. The record room must be properly equipped and supervised.
6. Complete autopsies must be done under the supervision of a competent pathologist on at least 25% of fatal cases.
7. There must be easy access to an adequate medical library.
8. The Medical Staff shall hold conferences at least once a month for the review of their clinical work in the hospital, the presentation of cases, and discussion of subjects of scientific interest.
9. In modification of the above requirements, provision is made for approval in part, or on an interim basis, of hospitals not completely fulfilling all the above requirements.

Application forms on which hospital facilities may be listed in detail may be obtained from:

JOHN E. PLUNKETT, M.D., F.R.C.P.[C], Honorary Secretary,
The Royal College of Physicians and Surgeons of Canada,
150 Metcalfe Street, Ottawa, Canada

SEVERE BURN

(area 162 square inches)

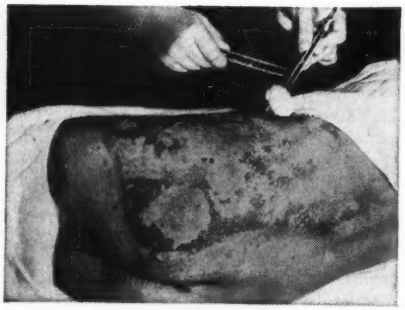

Fig. 1

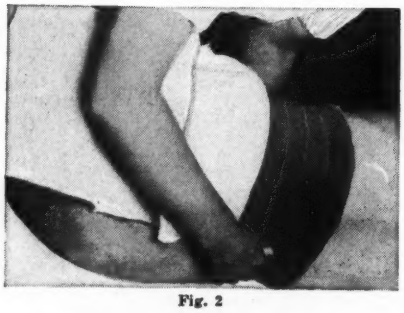

Fig. 2

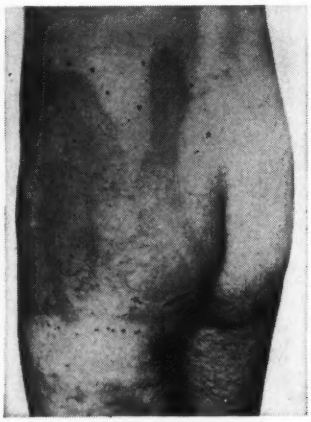

Fig. 3

A treatment using tulle gras pressure dressings and plaster fixation

CASE-HISTORY — The patient, a young man, was admitted to hospital, having been burnt by an electric blanket. The raw area measured 162 square inches. Excision of the burnt area was performed on the same day. Tulle gras (Jelonet) was applied. Fixation by Gypsona plaster of Paris bandages applied over the whole area, abdomen and thigh. The patient was given a blood transfusion.

Seven days later, the affected part was covered with thin razor grafts from both thighs and pressure dressing of Elastocrepe applied. Fixation was again secured with Gypsona plaster of Paris.

The patient was discharged to duty 7 weeks later.

The details and illustrations above are of an actual case. T. J. Smith & Nephew Ltd., Hull, England, manufacturers of "Gypsona" and "Jelonet", are privileged to publish this instance, typical of many, in which their products have been used with success in the belief that such authentic records will be of general interest.

Jelonet (tulle gras) is an open mesh gauze dressing impregnated with petroleum jelly and 1% Balsam of Peru. It is indicated as a dressing for skin grafts and in the treatment of wounds, burns, etc. Jelonet is sterilized ready for use and is supplied in 8 yd. continuous strips or in cut pieces 3¾" x 3¾".

SMITH & NEPHEW LTD.
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MONTREAL - QUEBEC

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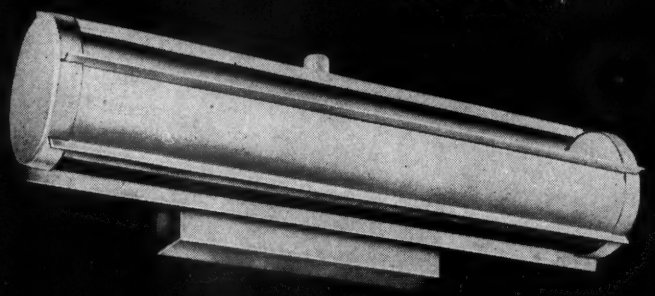
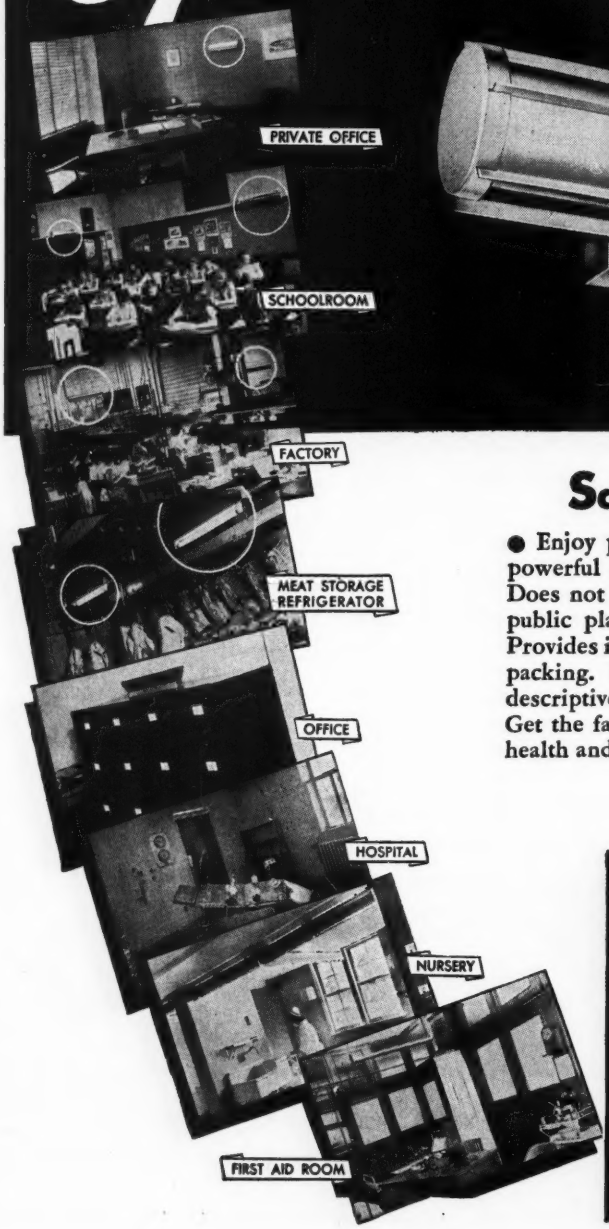
DESTROYING AIR-BORNE GERMS . . BACTERIA MOULDS





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● Enjoy purification of the air by ultra-violet radiation . . . a powerful agent for efficient destruction of air-borne bacteria. Does not affect room comfort. Curbs the spread of disease in public places, reception rooms, school rooms, nurseries, etc. Provides industry with protected air conditions in meat and food packing. Pendant or wall bracket types. Curtis offers complete descriptive literature, specifications and engineering service. Get the facts about this important new development to protect health and reduce colds.

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British Proprietaries

(Continued from page 44)

Federal Government in this country. A study of comparable advertisements and labels of like products sold in the two countries indicates a very real difference in present controls. Claims published in Canada are very much "toned down".

We are indebted to Mr. R. D. Whitmore, Chief, Inspection Services, Food and Drugs' Divisions, Department of National Health and Welfare, Ottawa, for the following comment on comparable legislation and regulations in Canada:

"It is not apparent from the published information if the demands of the Pharmaceutical Society of Great Britain for registration contemplate a formula openly disclosed to the public or whether the formula is to be held secret. In Canada, as is well known, both types of drugs for self-medication are available. The secret formula medicines are controlled by the necessity of securing a license under the Proprietary or Patent Medicine Act. Those which fail to secure or do not wish to secure such a license must be sold subject to the provisions of the Food and Drugs Act and Regulations.

"Speaking of the latter type the label must bear a complete list of the medicinal ingredients with a declaration of the quantitative proportional content of certain potent drugs which are named in Appendix B to the Regulations, and the recommended dosage of such potent drugs may not exceed limits imposed by that Appendix. The true name and address of the manufacturer and a statement of net contents must be given on the label.

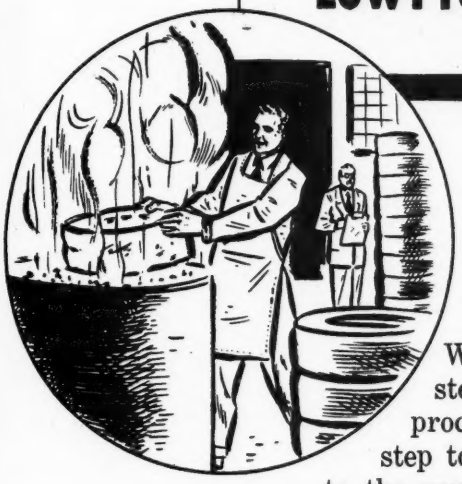
"In considering claims made for these open-formula preparations, whether by label or by advertisement, including radio advertisement, full weight is given to those sections of the Food and Drugs Act which prohibit false, exaggerated, misleading or deceptive statements or devices. With the good co-operation of the industry, marked progress has been made since 1927, when the misbranding of drugs became an offence under the Food and Drugs Act, in avoiding to a gratifying extent many of the practices about which complaints are so forcefully voiced by the Pharmaceutical Society of Great Britain. Where it seemed to be needed, specific regulations such as those which control vitamins have been promulgated.

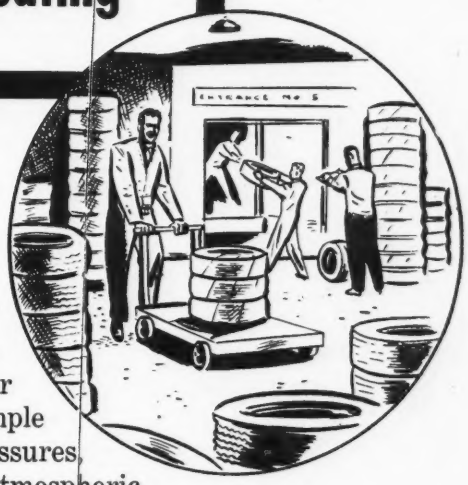
"To eliminate as far as possible the sale of articles for self-medication in conditions where delay in securing proper treatment would be dangerous or in those conditions where there is no known treatment, Section 6A was inserted into the Food and Drugs Act; it prohibits the importation, sale or offer for sale of foods or drugs represented by label or by advertisement to the general public as treatments for diseases, disorders or abnormal physical states included in Schedule A to the Act. This Schedule includes such afflictions as cancer, tuberculosis, heart disease, venereal disease, and so forth. Certain classes of products may only be produced in licensed establishments, inspected by officers of the Department of National Health and Welfare under the Food and Drugs Act, and the labelling of and claims for these are continuously regulated. Specified drugs which are

(Concluded on page 93)

STEAM

High Pressure for Processing
Low Pressure for Heating





Where high pressure steam is generated for processing, it is a simple step to reduce steam pressures to the required low or sub-atmospheric pressure . . . easily controlled and regulated by the Dunham Differential System for efficient comfort heating. It accomplishes this without the discomforts and fuel losses attendant upon "on and off", pulsating or cycling systems . . . regardless of outside temperature.

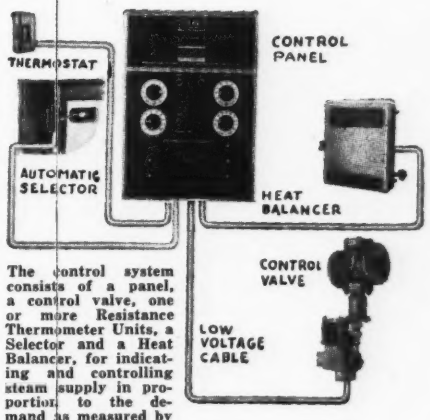
If you require steam for heat comfort and manufacturing or other services, let Dunham engineers collaborate with your consulting engineers or architect . . . for complete information on Dunham Differential Heating, C. A. Dunham Co. Ltd., 1523 Davenport Road, Toronto 4, Ontario. Offices from coast to coast.

TRUE HEATING COMFORT

Heat comfort requires a constant balance of the steam supply against the requirements for warmth. The requirements are variable, the steam supply should likewise be variable, but not intermittent. Only Dunham Differential Heating has the necessary flexibility to fully meet this variable requirement because no other system provides a continuous steam flow with automatic control of both steam temperatures and steam volume at sub-atmospheric pressures.

UNDIVIDED RESPONSIBILITY

The owner of a Dunham System is protected against the annoyances and expense caused by the divided responsibility in an "assembled" system of devices built by different manufacturers.



The control system consists of a panel, a control valve, one or more Resistance Thermometer Units, a Selector and a Heat Balancer, for indicating and controlling steam supply in proportion to the demand as measured by heat loss from the building construction.

The DUNHAM HEATING SERVICE

D & G DERMALON* and SURGILON*

Processed from nylon, these D & G sutures possess the smoothness, elasticity and impermeability that are characteristic of the basic substance.

Dermalon sutures, the products of years of intensive research and clinical observation, are improved monofilament strands characterized by absolute impermeability, a desired degree of elasticity and smoothness of surface. *Surgilon* sutures are braided from nylon filament and specially processed to eliminate knot slippage and assure non-capillarity, stability and compatibility. Both are obtainable through responsible dealers everywhere. Davis & Geck, Inc., Brooklyn, N. Y.

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"This One Thing We Do"

Royal College to Approve Residencies in Specialties

Announcement has been made that the Royal College of Physicians and Surgeons of Canada is prepared to receive applications for approval of residencies in medicine and surgery, and a number of specialized fields in medicine and surgery. Listing of approved residencies will be made by the Committee on Approval of Hospitals for Advanced Graduate Training.

This approval of residencies is not to be confused with the approval of hospitals for the training of interns which has been conducted by the Canadian Medical Association since 1931. This latter activity is still being maintained in the interests of medical education by the Canadian Medical Association, but the approval now being undertaken by the Royal College is for residencies providing more advanced training than that given in the usual internships. One forms a preparation for the other.

Elsewhere in this issue formal announcement by the Royal College of Physicians and Surgeons of Canada relevant to this development is set forth in more detail. Emphasis is placed upon indoor and outdoor services providing sufficient variety of clinical material and a sufficient number of patients to provide opportunity for training and experience; upon adequate organization of the medical staff; provision of adequate laboratory, radiological and other facilities; accurate and complete medical records with a well organized medical records department; autopsies on at least twenty-five per cent of fatal cases, and easy access to an adequate medical library.

Further information may be obtained from the Honorary Secretary, Dr. John E. Plunkett, The Royal College of Physicians and Surgeons of Canada, 150 Metcalfe Street, Ottawa.

High Honour Awarded Toronto Dean of Medicine

Dr. W. E. Gallie, recently retired head of the department of surgery and dean of medicine in the University of Toronto, has been awarded the honorary medal of the Royal College of Surgeons of England. This is one of the most coveted distinctions to be achieved by a surgeon and only twenty medical men have received the award since it was instituted in 1902. Among those honoured have been Sir James Paget, Lord Lister and Sir George Makin.

Fair Reasoning

. . . there is little use promising free hospital care to persons joining co-operative schemes if there are no hospital beds to put them in, and not enough nurses to care for them. Moreover, the time will come when the towns and cities will grow tired paying deficits on hospitals that are used by outsiders, and where people from other municipalities make up most of the patients. — *Editorial, Fergus News-Record.*

White Man Shows Way to Success

Robert Hunter, a Cree Indian from Moose Factory, has come to the conclusion that strange indeed is the white man's way when his red brother comes down from the north to visit his son in hospital.

Some months ago the white man's government discovered that Hunter's 13-year-old son Michael was showing signs of tuberculosis and arranged for the lad to be brought down to the big sanatorium at Weston near Toronto.

This, thought Hunter, was a good thing and showed that the white man's government was interested in the welfare of the red man and was anxious to do right by him. When the government arranged for Hunter himself to come down to Toronto last week-end and visit young Michael, the Indian decided the white man was not only fair and honorable but also tops.

But now Hunter doesn't know whether the white man is so smart, at that.

He stepped off the train at the Union Station early Sunday morning and saw Toronto for the first time. He couldn't speak much English, but depending upon the white man's well known wit and sharpness, he undertook to tell a station attendant that he wanted to go to Weston hospital to see his son.

The station attendant caught on immediately and told the Indian to relax while he called the hospital.

"I've a patient waiting for you down here," the attendant announced when he reached the hospital by phone.

"It's OK, they're coming right after you," he told Robert when he hung up.

Robert smiled gratefully. Truly, he thought, the white man was a good guardian.

In a few minutes an ambulance arrived and Robert was invited to enter. Arriving at the hospital, he was ushered into the receiving ward and told to get ready for bed.

Deciding that the white man retired early indeed — it being only 8 o'clock in the morning — Robert dutifully removed his clothes, climbed into a night shirt and hit the hay. Then he waited for his son.

But instead of his son, a nurse arrived with a thermometer, which she inserted into Robert's mouth. Robert tried to explain that he was anxious to see his boy, but as he was speaking in Cree and had a mouthful of thermometer, the nurse couldn't understand him and just smiled reassuringly.

This went on for quite a while, until Robert finally began to get a little tired of the attention the white man insisted upon showing his red brother. But when he tried to get up out of bed, he was gently but firmly shoved back again. Bewildered, Robert lay staring at the ceiling, wondering how many moons must pass before he would be allowed to visit his son.

Finally the nurses decided that what the new patient required was a few friendly words of greeting from some one of his own race. So they brought another Cree in from a ward down the hall and introduced him to Robert.

Inasmuch as there was no one else

(Concluded on page 98)

Wyeth

CONESTRON

FOR MENOPAUSAL SERENITY

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NATURAL CONJUGATED ESTROGENS
(equine)

ORAL THERAPY WITH CONESTRON provides safe, dependable control of menopausal symptoms and restores the patient's sense of well-being.

ORAL THERAPY WITH CONESTRON is relatively free from undesirable side effects.

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CONESTRON TABLETS

May be prescribed in any quantity. Available at all pharmacies in two strengths.

.625 mg. TABLETS

1.25 mg. TABLETS

Wyeth
Registered Trade Mark

JOHN WYETH & BROTHER (CANADA) LIMITED • WALKERVILLE, ONTARIO

Correspondence

Postscript to July "London Letter"

Dear Mr. Editor:

It is necessary for me to add a postscript to the report of the case in my letter published in your July issue. The report from which I quoted stated that the drug was sent up "as a sterile solution for injection and in an open flask plugged only with cotton wool at the top because it was for immediate use and was not a stock preparation to be kept in the theatre". The Times Law Reports, vol. lxiii at p. 318, gives the additional information, of which your readers will realize the importance, that the flask was "marked in large letters on the outside, 1 per cent cocaine and 1-20,000 adrenaline". The evidence was that the sister watched a nurse pour the contents into a bowl on the trolley from which the sister filled the syringe and handed it to the surgeon. There was a conflict of evidence as to what ensued in its bearing upon the surgeon's responsibility to check the contents of the syringe but it appeared that he did not see the original flask as sent up from the dispensary. The part of The Times Law Reports containing this report can be obtained separately from the office of the Times for eighteenpence.

"Londoner"
(C. E. A. Bedwell)

* * * *

A Reply

to the article "Make Room for the Engineer in Hospital Planning", by K. B. Gillies, in the July issue.

To the Editor:

The article appearing in the July issue of *The Canadian Hospital,* entitled *Make Room for the Engineer in Hospital Planning,* has, without doubt, caused no little controversy and perhaps some amusement to those architects who have made a specialty of hospital planning and design.

The architect who has specialized in this class of work knows well from experience that to plan properly either a small or a large hospital is perhaps one of the most complicated projects. With all due respect to the author of the above article, it is apparent he does not realize that it takes some years of personal experience and practice to understand fully the working conditions of the modern hospital. One fails to see where such a great opportunity exists for the engineering profession that they should assume that they can improve on the work of our hospital architects who, through long experience are turning out creditable hospital buildings in every province of Canada.

A group of single rooms and wards does not constitute a hospital, neither does a pleasingly designed facade. A good working hospital is one where, in its planning stage, hospital technique has been given due emphasis and stress. In addition, there are so many services to be provided that it would take pages to describe each separate department. All of these services must be so placed in relation to the patient wards as to facilitate the proper care and treatment of patients, so planned as to enable the operating of the

(Concluded on page 96)

Postoperative Wound

(Concluded from page 37)

the date these sutures are to be removed.

Emergency Treatment

Despite the most careful preoperative preparation, the most exacting surgical technique, and the most dutiful postoperative nursing care, there are those patients who, because of prolonged illness, advanced disease, age and debility, even when prepared and brought to their optimum for surgery, will still occasionally fail to heal an abdominal incision. It is mandatory, therefore, that the institution be organized to meet this emergency when it occurs. Lest grave time be lost, the entire staff must be schooled, as for all other emergencies, in the proper chain of command. In order to fix responsibility clearly and to avoid the elimination of any single important detail, we have the established rule that the nurse immediately in charge of the patient notify the intern, who after examining and protecting the wound in this instance will notify the resident. The resident bears the responsibility of notifying the surgery, transporting the patient to the surgery and notifying the attending surgeon. The charge nurse is responsible for reporting all such accidents to the superintendent and hospital management which, in turn, covers insurance angles, if any, involved.

All of the factors mentioned as necessary for the initial closure of the wound are even more necessary and sometimes more difficult for the secondary closure. Standardization of the procedure with the use of general anaesthesia, utilizing intravenous sodium pentothal to eliminate the excitement stage of induction and executing the closure with through-and-through steel sutures exteriorized and tied over gauze has shortened, on our service, the time of exposure of abdominal contents between the actual evisceration and the closure, the duration of the secondary operation, and resulted in satisfactory secondary healing. Such standardization, with an efficient chain of command, an immediately available effective surgical team and anaesthetists must rest with the hospital administration.

Probably hospital management should also feel it their responsibility to encourage occasional reviews of such emergencies at their staff meetings. These reviews would include advances in technic and physiology, which have to do with prevention and treatment, and the responsible chain of command when emergencies arise.

Brigadier C.H. Playfair

Brigadier C. H. Playfair, superintendent of the Mountain Sanatorium, Hamilton, Ontario, died on August 13th at the age of 48.

Dr. Playfair graduated from Queen's University in 1924. He enlisted in September, 1939, and shortly after went overseas with the 5th Field Ambulance. Following a distinguished military career which included the Spitzbergen expedition and the campaigns of Sicily, Italy and France, he received the C.B.E.

Two years ago, on his return from overseas, he was appointed superintendent of the Mountain Sanatorium.

Dr. Playfair is survived by his wife, two children and one brother.

Dominion Report Reveals Shortage of Sanatoria Beds

THE Dominion Bureau of Statistics at Ottawa has released its annual report on tuberculosis institutions, this edition being based on figures for the year 1945. Besides a study of the types of cases being treated, the beds available and an estimate of current needs, a section of the report deals with the work of tuberculosis clinics across Canada.

The number of sanatoria, plus public hospitals with tuberculosis units, which reported to Ottawa in 1945 was 84, an increase of four over the 1944 figure. Of these four, three are D.V.A. hospitals with a total capacity of 457 beds.

The total bed capacity of all institutions in 1945 was 12,088, an increase of 512 beds over those reported in 1944. The total days' care given to all patients amounted to 3,885,617 and the daily average bed occupancy was 89 per cent.

The estimated cost per patient day for all sanatoria was $3.17, while in 1944 the average cost was $2.88.

The total personnel caring for tuberculosis patients was 4,942, an increase of 531 over the figures given for 1944. On the other hand, while there was an increase of 71,803 days of patient care, the number of graduate and affiliate nurses fell from 873 in 1944 to 861 in 1945.

Revenue and Expenditure

The total operating revenue for all sanatoria was $9,371,622, of which revenue $514,820 or 5.5 per cent came from patients; $991,354 or 10.6 per cent from municipalities; $5,679,502 or 61 per cent from provincial governments; $1,243,958 or 13 per cent from the Dominion Government; and $941,988 or 10 per cent from other sources.

Total expenditures amounted to $10,188,627, an increase of $1,254,095 over expenditures for the previous year.

Movement of Patients

Patients in residence in all institutions on January 1, 1945 totalled 10,365 and in December the number was 10,721. Admissions during the year numbered 13,253, making a total of 23,618 under care during the year as compared with 22,115 in 1944. Of the 13,253 admissions 70 per cent were new cases. There were 12,897 discharges, which number includes 2,177 deaths.

Of the 13,253 admissions, 81.3 per cent had pulmonary tuberculosis, 5 per cent had pleurisy with or without effusion, 4 per cent had non-pulmonary tuberculosis, 4.1 per cent were non-tuberculous, 5.0 per cent were undiagnosed, while suspects, contacts and babies born in hospital comprised the remaining 0.6 per cent. Of the 10,781 pulmonary cases admitted, 38.4 per cent were moderately advanced and 35.1 per cent were far advanced.

Of 11,958 admissions, including pulmonary, non-pulmonary tuberculosis and pleurisy, 64.2 belonged in age groups ranging from 15 to 34 years. Of the non-pulmonary admissions 56 per cent belonged to these age groups. The average age of Canadian admissions was 28.2 compared with 28.4 in 1944; of British born 41.9 and of the European-born 44.5 years.

(Concluded on page 102)

Sanatorium Requirements for Canada

(Estimate for 1946, based on 1945 figures.)

Beds available in 1945	11,869
New beds planned or under construction for 1946	2,487
Estimated beds available for 1946	14,356
Total beds required on basis of 3 beds per death	18,459
Bed Shortage for tuberculous patients	4,103

Chest X-Ray Program

(Concluded from page 35)

ment and operations has been the subject of considerable discussion, especially as to whether or not a small charge for the chest film should be made to the patient. In some institutions these expenses are borne in full or part by the hospital or a local voluntary group, such as a tuberculosis association or the municipality or state.

There is a general agreement among all those who have had experience with this program, that the operation of such a service if properly carried out, is simple, cheap and efficient. The results have amply proved their value from the standpoint of public health, welfare of the patient and increased hospital diagnostic efficiency, along with protection to the hospital staff. It is to the interest of both governmental and municipal health agencies to cooperate with local voluntary organizations in assisting general hospitals to institute this program.

British Proprietaries

(Concluded from page 78)

potentially dangerous for self-medication, such as barbiturates, sulphonamides, thyroid and others, may only be sold to the general public upon prescription.

"The Departmental attitude towards the use of testimonials is widely known and their use is certainly not extensive.

"It can be repeated that the cooperation of the industry has been an important factor in reaching the present level. There is, however, much yet to be done for the protection of the public and of the reputable manufacturer. In this connection, as soon as it becomes possible, a guide prepared for manufacturers and advertisers will be submitted to the industry."

Dr. Charles Vezina Honoured

Dr. Charles Vezina of Quebec, professor of surgery at Laval University and president of the Medical Society of the University Hospitals, Quebec, has had conferred upon him this month the distinction of being named Chevalier de la Legionnaire d'Honneur in recognition of distinguished services.

Internship Approval List

Revised by C.M.A. Committee

The Committee on Approval of Hospitals of The Canadian Medical Association has issued its 1947 revised list of hospitals approved for the training of interns. There are now sixty-six hospitals on the list furnishing approximately 1,306 internships. This number includes 273 final year internships under university affiliation. Hospitals recently added to the list are:

Oshawa General Hospital
Edmonton General Hospital
Wellesley Hospital, Toronto
Brantford General Hospital (reinstated)
Shaughnessy Hospital, Vancouver (D.V.A.)
Colonel Belcher Hospital, Calgary (D.V.A.)
Deer Lodge Hospital, Winnipeg (D.V.A.)
Westminster Hospital, London (D.V.A.)
Christie St. (and Sunnybrook), Toronto (D.V.A.)
Ste. Anne's Hospital, Ste. Anne de Bellevue, Que. (D.V.A.).
Queen Mary Hospital, Montreal (D.V.A.)
Camp Hill Hospital, Halifax (D.V.A.)

Inclusion of a hospital on the "approved" list refers to the basic training as provided in a general internship. Its relationship to training for the practice of the specialties is that the Royal College of Physicians and Surgeons of Canada recognizes the basic training provided in "approved" hospitals as the common and fundamental background for doctors who may undertake further training leading to certification in one of the recognized specialties. The Royal College of Physicians and Surgeons of Canada has recently announced the bases of approval of hospitals for graduate training in the specialties (see pages 73 and 82.)

As there are a number of good hospitals in Canada which can provide their interns with an excellent training, but which, for one reason or another, do not fully comply with the provisions of the Basis of Approval, the Committee has placed these hospitals upon a "commended" list.

There are eight hospitals in this group providing thirty graduate and undergraduate internships.

Priest and Baker

A shipment of flour has arrived at the Columbian mission hospital in Nancheng, China, from the St. Columban's headquarters in St. Columbans, Nebraska. The kitchen of this hospital was damaged during the war and the Rev. Thomas Fofy, Columbian missionary and rector of the native seminary, not only offered the seminary kitchen to the hospital but taught his staff how to bake bread for the hospital patients!

Hospital Progress, June, 1947.

Correspondence

(Concluded from page 88)

hospital at minimum cost and, at the same time, make it possible for doctors, nurses and other staff members to carry out their several duties efficiently.

To carry out such a job properly demands a specialist and because of this demand the hospital architect has evolved. This specialist is first of all an architect, however, for in the whole building industry he only is trained to reflect in a building the spirit of the work conducted in that building.

From the above it is evident that the planning requirements must take precedence over the engineering services in which heating, electrical and structural engineers, each have a part. The importance of these services is fully realized and they are usually employed by the architect after he has received approval of his sketch plans and is ready to start work on the contract drawings.

In conclusion it can safely be stated that the hospital architect is the one and proper person to prepare the plans of any hospital. There is no need to educate the engineer in this particular field of work which is as much outside his province as would be the case should any architect assume that he was qualified to undertake with hope of success any major engineering problem. To the author's suggestion, appearing in his article, that there may be objections on the part of hospital planning boards to the employment of engineers in favour of architects and his own question, "Where can one find engineers competent to carry out work of this nature?", we as hospital architects give full endorsement and would also add the word "Why".

—*Frank G. Gardiner, M.R.A.I.C., Gardiner and Thornton, Architects, Vancouver, B.C.*

Coming Conventions

September 21-22—A.C.H.A. meeting, St. Louis, Mo.

September 22-25—American Hospital Association, Jefferson Hotel, St. Louis, Mo.

October 14-15—Saskatchewan Hospital Association, Bessborough Hotel, Saskatoon.

October 15—Manitoba Hospital Association, Royal Alexandra Hotel, Winnipeg.

October 16-18—Canadian Hospital Council, Royal Alexandra Hotel, Winnipeg.

October 20-25—Alberta Institute on Administration, Edmonton.

October 25—Associated Hospitals of Alberta, Edmonton.

October 28-31—British Columbia Hospitals Association, Victoria.

November 3-5—Ontario Hospital Association, Royal York Hotel, Toronto.

Provincial Notes

(Concluded from page 64)

long by 44 feet wide and is designed so that additions can be made at a later date.

* * * *

Quebec

VAL D'OR. Excavation of ground for the foundation of the new half-million dollar hospital is under way. The new hospital will be known as St. Saviour's and it will have a capacity of sixty beds within its five storeys. Architects' plans call for a concrete and frame building with brick exterior and stone trimming. It will be 157 feet long by 45 feet in depth and rectangular in shape, with a service wing in the rear.

Progress in Red Cross Construction Program

Red Cross headquarters in Toronto has announced that construction has begun on three outpost hospitals. Huntsville will have a 26-bed, cottage-type hospital; Bancroft and Nipigon, 20-bed institutions.

Each new outpost will include glass-partitioned nursery cubicles for babies. At Bancroft and Huntsville hospitals a public health wing is attached, from which a public health program may be carried on.

The total cost will be about $500,000. The local branch of the Red Cross underwrites a third of the cost; the province grants one-third and the Ontario Red Cross headquarters pays the remaining third. There are at present twenty-six Red Cross outpost centres in the province.

White Man Shows

(Concluded from page 86)

beside the two of them present who could speak Cree, no one knows just what was the exact conversation. But it's a safe bet that if the white man could have understood it, his ears would probably have been much redder than those of his red brother.

At any rate, the whole thing was cleared up then and there and Robert finally got to see young Michael. But the boys around the camp fire back at Moose Factory will chuckle for a long time when Robert tells them how he spent his first Sunday in the land to the south where the visiting red man has to go to bed at 8 o'clock in the morning.

—Bruce West, Globe and Mail.

$75,000 for Cancer Study

Awards totalling more than $75,000 have been made this year by the Ontario Cancer Treatment and Research Foundation to further cancer research in the province, Arthur R. Ford, chairman of the Foundation, has announced.

Directing the work in Ontario's medical schools and hospitals are a group of scientists from the University of Toronto and research directors from other institutions.

On the basis of previous grants totalling more than $191,000, other investigations are being carried on. Several of the projects are to determine whether large groups of the population can be examined for cancer.

Montreal General Hospital

(Concluded from page 33)

and in later years A. D. Blackader, H. A. Lafleur, F. J. Finlay, George M. Armstrong and E. M. Eberts, not to mention numerous others more recently and presently connected with its staff.

A famous nurses' training school has been built up with the growth of the hospital. Until 1875 the nursing had followed along the old-fashioned lines best known to the day. In that year Florence Nightingale was induced to send four of her nurses from the St. Thomas Hospital in London, and these undertook the proper care of patients. It was not until April 1, 1890, that a nurses' training school was definitely established under the direction of Miss Nora Livingston. For nearly fifty years the hospital has continued to graduate young women whose influence in the hospital field has been felt across the continent.

While service to the sick has been the primary purpose of the Hospital, it can also lay claim to the distinction of launching the McGill University Medical School on its career of greatness. From the first, as described by Dr. Maude E. Abbott, in an article published in *Surgery, Gynaecology and Obstetrics,* it was recognized that the Hospital was to be used as the actual headquarters of a medical school and for the instruction of students who were to be admitted freely to the wards for teaching and study. First steps in the organization of Canada's first Medical School, the Montreal Medical Institution, were taken six months after the Hospital opened its doors. At a meeting of the medical officers of the hospital held "to consider the expediency of establishing a medical school in this city" Drs. Stephenson and Holmes were deputed "to draw up the considerations that seemed to warrant such an endeavour at this Hospital". The organization of the Montreal Medical Institution was carried out and the young institution sprang at once into activity and carried on with a full curriculum, but without University status, until the year 1829.

It was in this year that a serious and critical situation arose in the affairs of McGill College which, though founded in 1811 by the will of James McGill and incorporated in 1821, as yet existed only on paper. In order to fulfill the conditions of the will and to secure the bequest of the founder it had become essential for the university to institute academic activities. The established reputation of the young teaching body attracted the attention of the Royal Institution for the Advancement of Learning, a body framed by Act of Parliament in 1801, and the trustee of the will; as the outcome of negotiations the members of the Montreal Medical Institution were formally "engrafted upon" the College as its Medical Faculty. The Medical Faculty, of which the McGill Faculty is the direct continuance, was thus the pioneer Faculty of the University and it continued to be the only one in active operation during the next twenty-five years. Its founders were men of high professional status who established the "clinical advantages" of McGill and which were recognized both in England and America as among the finest available.

Hospital Statistics

(Concluded from page 54)

patients. Patients under care during the year numbered 50,977 with an average stay of 18.2 days.

Dominion Hospitals

The report includes, finally, a listing of the hospitals operated by the Dominion Government. There are 22 under the Department of National Health and Welfare of which 6 are for Quarantine and Sick Mariners and 16 are run by the Indian Health Services branch. There are 26 Veterans Affairs hospitals and 89 under the Department of National Defence. These make a total of 137 Dominion hospitals.

A New Queen is Crowned

(Concluded from page 56)

ing evenly and well, it is quite pendulant. When well along with her great record, it was discovered that she had developed cystic ovaries. For fear of upsetting her production, treatment was delayed until completion of her lactation when hormone therapy was tried. She has apparently responded well and, while at this writing it is too early to be sure, they are quite hopeful that she is or soon will be carrying her fourth calf.

With her 1,139 lbs. of fat, O.H.H. Abbekerk Darkness has topped the record of the former world champion 2X producer, Doncrest Peg Top Burke, who produced 1,108 lbs. fat. "Peg Top" retains her leadership for milk with 31,935 lbs.

Champion makers are hearing good reports of another young producer at the Orillia Hospital. A daughter of C.V. Dark Abbekerk Baron, sire at the Hamilton institution farm, O.H.B. Alma Pontiac Baroness has a junior 2-year-old record of 21,519 lbs. milk, 3.95 per cent, 851 lbs. fat on 3X, a record which is second for fat and third for milk in that class in Canada.

Dominion Report

(Concluded from page 92)

Of the 11,958 admissions, 18.0 per cent were English; 9.0 per cent were Irish; 11.5 per cent were Scottish and 0.4 per cent Welsh. French admissions totalled 37.2 per cent. European races contributed 16.0 per cent. Asiatics and Negroes accounted for 2.3 per cent, while Indians and Eskimos made up 5.6 per cent.

Tuberculosis Clinics

That the clinics are performing a meritorious preventive service is indicated in the fact that the total number of tests and treatments given and examinations made during the year number 432,767. Contacts examined for the first time totalled 18,497.

Mass surveys were conducted by seven of the provinces during 1945 though only six are represented in the tables given in this section. The survey for British Columbia is included under the Division of Tuberculosis Control in an earlier section. For the six provinces appearing in the table given, a total of 526,413 persons were examined, which, added to the total examinations made by the clinics, raises the total examinations made during the year to 958,-180, an increase of 27 per cent over those made in the previous year.

WANTED X-RAY TECHNICIAN
for Holy Cross Hospital, Calgary. Apply to Personnel Manager, stating age, qualifications, experience, and salary expected.

TECHNICIAN FOR PATHOLOGY LABORATORY

Wanted—Male or female technician for pathology laboratory in a 150-bed general hospital. Salary $150.00 per month plus maintenance. Apply stating qualifications, age and experience to the administartor of the Public General Hospital, Chatham, Ontario.

WANTED—ASSISTANT DIETITIAN

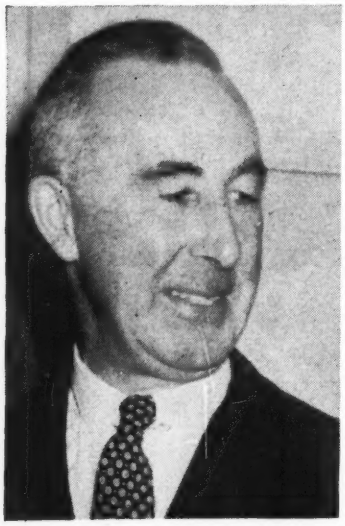
for 135 Bed Hospital — also, Clinical Supervisor. Apply stating qualifications, experience and salary expected, to Superintendent, Guelph General Hospital, Guelph, Ontario.

WANTED—SUPERINTENDENT OF NURSES

Victoria Public Hospital, Fredericton, N.B. 150 bed hospital. Apply to Mrs. B. H. Hagerman, Chairman, Nurses' Committee, 62 Alexandra St., Fredericton, N.B.

Administrator Appointed At Royal Jubilee

Following the resignation of Dr. Morley Beckett, Mr. Charles Morrison has been appointed administrator of the Royal Jubilee Hospital in Victoria, B.C., as of September 1st. Dr. R. G. McNeely, Director of the Department of Pathology, has been named Acting Medical Director.



Charles Morrison.

Mr. Morrison entered the service of the Royal Jubilee in 1924 as accountant and for more than five years has been Secretary of the Board and Business Manager.

Dr. Beckett, who entered upon his duties as administrator of the hospital in March of this year, has accepted an appointment in the Medical Service of the United States Veterans' Administration, with the grade of Chief. His initial assignment will be inspection of Veterans' Hospitals throughout the States of the Pacific Northwest and Alaska.

University of Toronto Appointment Announced

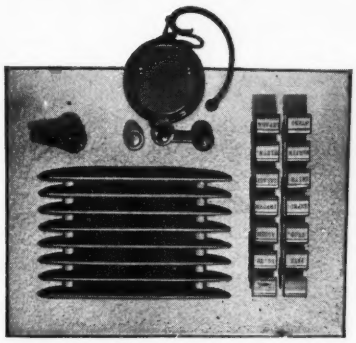
Dr. Robert Bews Kerr has been appointed assistant professor in the faculty of medicine, in charge of the department of therapeutics at the University of Toronto, according to a statement made by President Sidney Smith.

Dr. Kerr was graduated from the University of Toronto in 1933 and entered upon post-graduate studies in the department of medicine. Four years later, while studying in England, he became a member of the Royal College of Physicians and Surgeons. Dr. Kerr returned to Canada in 1939 to practise and teach at the University of Toronto.

Canadian Delegate to World Health Organization

Dr. G. D. W. Cameron, Ottawa, deputy minister of national health, was the Canadian delegate to the fourth meeting of the interim commission of the World Health Organization in Geneva this month. Dr. Clarence Routley, General Secretary of the Canadian Medical Association, was present as alternate delegate. The advisors named were Dr. Guerin Lajoie, Montreal; Dr. M. R. Bow, Edmonton, Deputy Minister of Health for Alberta; and John Halstead, Department of External Affairs, Ottawa.

Dr. Cameron will also attend the first full conference, in Paris, of the World Medical Association of which Dr. Routley is chairman.



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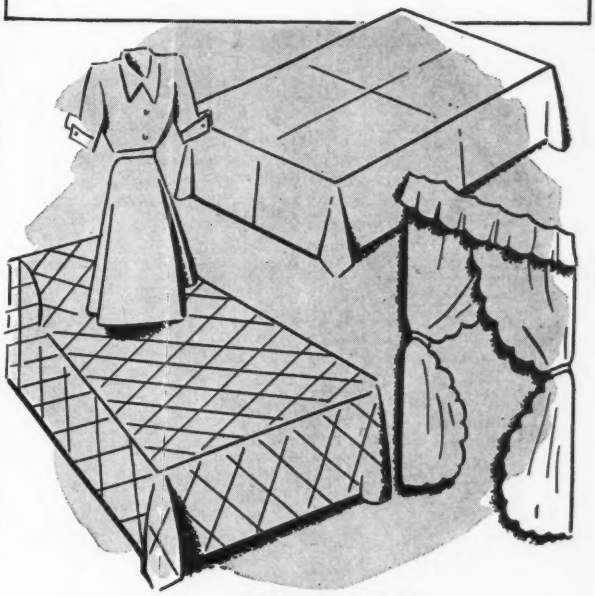

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